PHYSICAL EXAMINATION FORM FOR ALL STUDENTS

PLEASE RETURN COMPLETED HEALTH EXAMINATION FORM TO THE SCHOOL.

Immunization Records Must be Attached to this Form

Student Name: _____

Date of Birth: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN

DATE OF EXAM: _____

IMMUNIZATIONS (attach record)

HISTORY

Asthma: ○ No ○ Yes
ADHD: ○ No ○ Yes

Chronic Conditions/Major Surgeries: (list, give date):

_____

_____

Allergies (list):

_____

_____

Medications (list):

_____

_____

_____

ORTHOPEDIC HISTORY (for sports participation)

Previous Injury Date: _____

Explain: _____

_____

_____

PHYSICAL

Height: _____ Weight: _____ 8/P: _____ Pulse: _____

Eyes: R: 20/_____ L: 20/_____ Hearing: _____

Scoliosis Screening: _____

Review of System: _____

Note any problems: _____

_____

ORTHOPEDIC EXAM (for PE Participation)

Back/Neck/Shoulders/Extremities: _____ WNL: _____

If not, please explain: _____

_____

Recommendation for PE/Sports: ○ Full ○ Limited ○ None

Clearance withheld until: _____

If limitations, please explain: _____

_____

SIGNATURE OF EXAMINER _____

Name (please print): _____

Address: _____

Phone: _____

Special Seating Recommendations: _____

Medical Treatment Needed at School: _____

Other Health Recommendations: _____

Signature of Parent: _____ Date: _____