PHYSICAL EXAMINATION REPORT

STUDENT'S NAME ____

(last) (first) (middle initial) (phone)

____

(address) (city) (state) (zip)

Date of Birth ____________ Sex ____________ Grade level in Sept. ____________

Mother's Name ____________ **Father's Name** ____________

Address ____________ Address ____________

Phone ____________ Phone ____________

Student's Medical History

(to be completed by parent/guardian or physician)

	Yes	No	Date	Description/Reason
Allergies	☐	☐		
Asthma	☐	☐		
Blood Disorders	☐	☐		
Cancer	☐	☐		
Chicken Pox	☐	☐		
Diabetes	☐	☐		
Headaches	☐	☐		
Hearing Problem/Hearing Aid	☐	☐		
Heart Disease	☐	☐		
Hepatitis	☐	☐		
High/Low Blood Pressure	☐	☐		
Hospitalizations	☐	☐		
Kidney/Urinary Tract Problem	☐	☐		
Medication Reactions	☐	☐		
Menstrual Disorder	☐	☐		
Mononucleosis	☐	☐		
Muscular Disorder	☐	☐		
Orthopedic Disorder	☐	☐		
Rheumatic Fever	☐	☐		
Scoliosis	☐	☐		
Seizure Disorder	☐	☐		
Strep Infections	☐	☐		
Surgery	☐	☐		
Ulcer/Gastrointestinal Disorder	☐	☐		
Visual Problem/Glasses/Contact Lenses	☐	☐		
Other	☐	☐		

Is the student now under the care of a physician? ______

Does the student take any regular medication? Please name medication and dosage below.

____

Has the student ever been advised by a physician not to play a sport? ____________

Are there any other physical or emotional conditions that might bear on this child's abilities or performance?

____

COMMENTS: ____

Parent/Guardian Signature: ____________ Date: ____________

PHYSICIAN'S EXAMINATION

Height ________ Weight __________ Blood Pressure _____________ Pulse__________

Vision Without Correction: R 20/_____ L 20/_____ Both 20/_____

Vision With Correction: R 20/_____ L 20/_____ Both 20/_____

Hearing Right________________________ Left _______________________________

Nutrition (please note significant weight gain or loss in the past year)_______________________

Head & Neck _____________ Lungs _______________ Extremities _____________

Nose _____________ Heart _______________ Neurological _____________

Eyes _____________ Abdomen _______________ Urinalysis _____________

Ears _____________ Back _______________ Hemoglobin\Hematocrit _____________

Throat _____________ Genitalia _______________ Scoliosis Screening _____________

Chest\Breast _____________ Hernia _______________ If positive, treatment? _____________

Comments: ____

____

TO BE COMPLETED BY PHYSICIAN

A. **New Students** - Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.

Returning Students - Please note date of last booster and any other immunization that has been given in the last year.

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
Diptheria, Tetanus, Pertussis – (DTaP) *(If Td or DT , write in corner box)							
Tdap							
Polio-Inactivated Vaccine (IPV) If oral polio, write (OPV) in corner box							
MMR (Measles, Mumps & Rubella)					Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Haemophilus B (HIB)**					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Varicella					Measles	Date:	Titer:
Pneumococcal Conjugate**					Mumps	Date:	Titer:
Meningococcal					Rubella	Date:	Titer:
Hepatitis A***							
Influenza**							
HPV (Human Papillomavirus)***							
Other *(Specify)*							
*DT Requires valid medical exemption ** Required for Day/Child Care (2m-5yo)	Medical exemption attached ☐ ***Not Required		Religious exemption attached ☐ Provisional admissions attached ☐ Date Granted:				

B. Mantoux Tuberculin Test Date______Result______If positive, did student have chest X-Ray?___Result

Based on this history/physical, this student:

__ may participate in competitive athletics and physical education activities.

__ has health problems, which prohibit participation in the following athletic activities:

____

Physician's Name (please print)______________________________

Physician's Signature ______________________________

Address ______________________________

Telephone ______________________________

Date of Examination: ______________________________