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: ______________________________