

**SCHOOL: \_\_\_\_\_ PHYSICAL EXAM**

*Physical exams are required for students entering Kindergarten, grade 6 and 9.*

*The following information may be released to the school nurse to be kept in confidential permanent school health record.*

Parent/Guardian signature: \_\_\_\_\_

Name \_\_\_\_\_ M / F Birthdate / / . Grade \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_

Visual acuity R \_\_\_\_\_ L \_\_\_\_\_ Hearing R \_\_\_\_\_ db L \_\_\_\_\_ db

Yes	No		Yes	No	
		Frequent headaches			Toileting problem
		Dizziness/fainting			Behavior/emotional prob.
		Seizures			Physical limitation
		Vision problem			scoliosis
		Hearing Problem			Heart disease
		Asthma/chronic cough			Chronic illness
		Allergy			Learning problem
		Frequent abdominal pain			Special diet needs
		Diabetes			Dental problem

**Lab dates and results:** TB Test \_\_\_\_\_ Type \_\_\_\_\_ Results \_\_\_\_\_ Rx \_\_\_\_\_

Lead screening \_\_\_\_\_ Urine \_\_\_\_\_ Hgb/Hct \_\_\_\_\_

**PROBLEM LIST**

**PLAN (meds, services, follow-ups)**

1	
2	
3	

**IMMUNIZATIONS:** (Exact dates MONTH/DAY/YEAR required.)

DPT	OPV/IPV	MMR	HIB	HBV
				1.
				2.
				3.
		XXXXXX		
		Pneumococcal	OTHER	
TD/dT	Varicella or Chicken Pox vaccine			
	Disease/titer			

Student may participate in a full school program including a vigorous physical education program and interscholastic athletics. (Specify limits if needed)

\_\_\_\_\_  
Physician (printed name)

(Revised 3/03)

\_\_\_\_\_  
Date of Exam

\_\_\_\_\_  
Physician Signature

