RSU1 SCHOOL PHYSICAL EXAM

Physical exams are for Pre-K, Kindergarten, gr. 6 and gr. 9

Name _____ Sex M / F Birthdate ___/___/__ Grade/Teacher_____

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 problem
		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 (decay/fillings/missing)

Specify if needed:_____

Lab dates and results: Lead screening _____ Urine _____Hgb/Hct_____

PROBLEM LIST	PLAN (meds, services, follow-ups)
1	
2	
3	

IMMUNIZATIONS (Exact dates MONTH/DAY/YEAR required) or attach copy

DTaP	IPV/OPV	MMR	HepA	HepB
1	1	1	1	1
2	2	2	2	2
3	3	MMRV		3
4	4	1		
5		2	OTHER	HPV
Tdap	Varicella (or disease date/titer)	Menactra		1
	1			2
Td	2			3

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

_____

_____

_____ _____ _____

Physician (printed name) Date of Exam Physician Signature

Please return form to school nurse.

revised 06/2016