

2020-2021 PHYSICAL EXAMINATION

Required for all new and current students on a yearly basis.

Must be completed by a physician

Student's Name: Last		First		Age:			
Date of Evaluation (must be within 3 months start of school year or admission): (mm/dd/yyyy)							
Health Assessment	Height: cm	B / P	/	Physical Examination			
	Weight: kg	Pulse:		1. Within Normal	2. Abnormal findings		
	BMI:			HEENT	1 / 2	Neurological	1 / 2
	<input type="checkbox"/> Age appropriate history completed			Lungs	1 / 2	Gastro Intest.	1 / 2
	<i>List any previous surgeries:</i>			Heart	1 / 2	Extremities	1 / 2
				Skin	1 / 2	Genital	1 / 2
				Urinary	1 / 2	Scoliosis	1 / 2
<i>Significant physical findings, comments, and recommendations for medical monitoring:</i>							
Screenings	Vision		Developmental				
	Screening with corrective lenses	<input type="checkbox"/>		Normal	Concern Identified		
	Pass	<input type="checkbox"/>	Emotional / Social				
	Referral made	<input type="checkbox"/>	Problem Solving				
	Dental		Language / Communication				
	Pass	<input type="checkbox"/>	Fine Motor Skills				
	Referral made	<input type="checkbox"/>	Gross Motor Skills				
	Auditory		Speech				
	Pass	<input type="checkbox"/>	<i>State / Clarify any concerns:</i>				
Referral made	<input type="checkbox"/>						
<input type="checkbox"/> Well child / No identified concerns to school programs or activities.							
<i>List any medical conditions identified that are important to school / physical activity (i.e. asthma, diabetes, seizure disorder, allergies, bone/joint diseases):</i>							
<i>List any restricted activities or special needs:</i>							
<i>List any medications student is currently prescribed (include dosage and frequency):</i>							
Physician Signature:				Date:			
Physician / Clinic address / Phone number (*please print or stamp)							
Name:			Phone Number:				
Address:							