2018-2019 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:			

☐ Age appropriate history completed

List any previous surgeries:

HEENT	1 / 2	Neurological	1 / 2
Lungs	1 / 2	Gastro Intest.	1 / 2
Heart	1 / 2	Extremities	1 / 2
Skin	1 / 2	Genital	1 / 2
Urinary	1 / 2	Scoliosis	1 / 2

Significant physical findings, comments, and recommendations for medical monitoring:

Screenings

Vision		**Developmental**		
Screening with corrective lenses	☐		Normal	Concern Identified
Pass	☐	Emotional / Social		
Referral made	☐	Problem Solving		
Dental		Language / Communication		
Pass	☐	Fine Motor Skills		
Referral made	☐	Gross Motor Skills		
Auditory		Speech		
Pass	☐	*State / Clarify any concerns:*		
Referral made	☐			

Medical Concerns

☐ Well child / No identified concerns to school programs or activities.

List any medical conditions identified that are important to school / physical activity (i.e. asthma, diabetes, seizure disorder, allergies, bone/joint diseases):

List any restricted activities or special needs:

List any medications student is currently prescribed (include dosage and frequency):

Physician Signature: **Date:**

Physician / Clinic address / Phone number (*please print or stamp)

Name: Phone Number:

Address: