

**PHYSICAL EXAMINATION**

STUDENT \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

**PHYSICAL EXAMINATION:** Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received. **\*An annual physical examination is required for participation in interscholastic sports. (\*Both sides must be completed.)**

- |                                           |                                     |                                              |                          |
|-------------------------------------------|-------------------------------------|----------------------------------------------|--------------------------|
| 1. BP _____                               | Pulse _____                         | 10. Speech _____                             |                          |
| 2. Height _____                           | Weight _____                        | 11. Nose _____                               |                          |
| Body Mass Index: _____                    |                                     | 12. Throat _____                             |                          |
| Weight Status Category ( BMI Percentile ) |                                     | 13. Tonsils _____                            |                          |
| less than 5 <sup>th</sup>                 | 5 <sup>th</sup> - 49 <sup>th</sup>  | 50 <sup>th</sup> - 84 <sup>th</sup>          | 14. Teeth and gums _____ |
| 85 <sup>th</sup> - 94 <sup>th</sup>       | 95 <sup>th</sup> - 98 <sup>th</sup> | 99 <sup>th</sup> and higher                  | 15. Skin _____           |
| 3. Urinalysis _____                       |                                     | 16. Glands (cervical, thyroid, other) _____  |                          |
| 4. Heart _____                            |                                     | 17. Nervous system _____                     |                          |
| 5. Breasts _____                          |                                     | 18. Hernia _____                             |                          |
| 6. Lungs _____                            |                                     | 19. Genitourinary _____                      |                          |
| 7. Eyes R _____ L _____                   |                                     | 20. Tanner I. II. III. IV. V.                |                          |
| With Glasses R _____ L _____              |                                     | 21. Orthopedic: scoliosis: positive negative |                          |
| 8. Visual Diagnosis _____                 |                                     | posture _____ feet _____                     |                          |
| 9. Ears: Otitis _____                     |                                     | structural defects _____                     |                          |
| Audiometric _____                         |                                     | 22. Abdomen _____                            |                          |
| P.E. tubes Yes _____ No _____             |                                     |                                              |                          |

SURGERIES: \_\_\_\_\_

SIGNIFICANT ILLNESSES / INJURIES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

**ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM**

Full Activity \_\_\_\_\_ Restriction \_\_\_\_\_ Recommendation \_\_\_\_\_

CURRENT MEDICATIONS (please list all medications and dosages):

\_\_\_\_\_

IMMUNIZATIONS (please fill in or attach record of immunization)

PROCEDURES / TESTS

DPT or DTaP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(3 required)

MMR \_\_\_\_\_ / \_\_\_\_\_  
(2 measles required)

TB Screening \_\_\_\_\_

Td or DT Booster \_\_\_\_\_

Varicella \_\_\_\_\_ / \_\_\_\_\_

Chest X-ray \_\_\_\_\_

Tdap \_\_\_\_\_

HIB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Lead Screening \_\_\_\_\_

Polio (OPV or IPV) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(3 required)

Hep B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(3 required)

Sickle Cell Test \_\_\_\_\_

PCV \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_  
Signature of Examining Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Physician's Address & Phone #  
**(PLEASE STAMP)**

