2017-2018 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
	☐ Age appropriate history completed			Lungs	1 / 2	Gastro Intest.	1 / 2
	List any previous surgeries:			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: