

A health examination is required for all first time entrants or all new students to the school. This information is required prior to the 1<sup>st</sup> day of school to be complete. For participation in sports, this physical examination is required each year to be completed after June 1, for the upcoming school year.

*(Physical and completed sports packet is required before student can practice and/or play any sport)*

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN Entering Grade \_\_\_\_\_ Year \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ SEX: M F BIRTHDATE \_\_\_\_\_  
First Middle Last MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
Street City Zip code

MOTHER'S NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
First Middle Last Home Work

FATHER'S NAME: \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
First Middle Last Home Work

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:  
NAME RELATIONSHIP TELEPHONE NUMBER(S)

1) \_\_\_\_\_

2) \_\_\_\_\_

PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHILD UP FROM THIS SCHOOL: \_\_\_\_\_

**Health History:** (Please explain any yes answers)

a) Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: \_\_\_\_\_ No: \_\_\_\_\_

b) Any known allergies; drug, environmental, food; describe: Yes: \_\_\_\_\_ No: \_\_\_\_\_

c) History of head injury, concussion, seizure, etc? Yes: \_\_\_\_\_ No: \_\_\_\_\_

d) History of any hospitalization or surgery; explain: Yes: \_\_\_\_\_ No: \_\_\_\_\_

e) Any spinal injuries or spinal defects: Yes: \_\_\_\_\_ No: \_\_\_\_\_

f) List **all** medications taken on a daily basis:

g) Note special concerns regarding participation in physical education, athletics or sports for you child:

h) Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth? Yes: \_\_\_\_\_ No: \_\_\_\_\_

**\*\*\*SPECIAL EMERGENCY REFERRAL INSTRUCTIONS\*\*\***

In the event that I cannot be reached or make arrangements for emergency medical attention at the time of illness/accident, I hereby authorize:

\_\_\_\_\_ to take my child to:  
Name of School

PHYSICIAN ADDRESS TELEPHONE #

HOSPITAL ADDRESS TELEPHONE #

Date of last Tetanus shot: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name (PLEASE PRINT) \_\_\_\_\_

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age:                    yrs.                    mos.	General Appearance			
Height (no shoes):            inches (            %)	Skin			
Weight (light clothing):      lbs.            oz. (            %)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: \_\_\_\_\_

**IMMUNIZATION RECORD**

month/day/year

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Booster	Booster
DPT/DTaP/Td (diphtheria,pertussis,tetanus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Other						

Tuberculin Skin Test; Date: \_\_\_\_\_ Result: \_\_\_\_\_ Chest X-ray; Date: \_\_\_\_\_ Result: \_\_\_\_\_

Hearing Screening	1 <sup>st</sup> screening		Hearing Screening	2 <sup>nd</sup> screening		1 <sup>st</sup> Vision Screening	2 <sup>nd</sup> Vision Screening
at 25 dB	R	L	at 25 dB	R	L	Distance Acuity:	Distance Acuity:
1000 Hz			1000 Hz			R20/ _____ L-20 _____	R-20/ _____ L-20/ _____
2000 Hz			2000 Hz			Pass _____ Refer _____	Pass _____ Refer _____
4000 Hz			4000 Hz			Fail _____	Fail _____
Date:			Date:			Signature:	Signature:

Scoliosis Screening: Pass \_\_\_\_\_ Fail \_\_\_\_\_ Refer \_\_\_\_\_ Comments: \_\_\_\_\_

**Patient Health History, Findings and Recommendations:**

Physical Activity: Restricted or Unrestricted (circle one) Explanation: \_\_\_\_\_

I have examined the child named on this form, and find that he/she is able to participate in the athletic and physical education programs of the school:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(stamped signature not accepted)

Please print physician's name and address: \_\_\_\_\_  
(MD / DO or PA or RNP working under the direction of a licensed physician)