

Department of Education PHYSICAL EXAM FORM ELEMENTARY STUDENTS



School:	

Student:			DOI	3:
Male Fem	nale		Grade:	HR:
Home Address:				
Father/Guardian:		Mother/0	Guardian:	
Place of work:		Place of v	work:	
Phone: Home:	Work:	Phone: H	ome:	Work:
Cell:		Cell:		
Email:		Email:		

PART I: IMMUNIZATION AND TB STATUS

A copy of the **Official Immunization Record** must be attached. Record must indicate the specific immunizations and results of a **TB Skin Test** and date on which they were received. Please refer to **Board Policy 337** or SOP 1700-009.

THIS PORTION TO BE COMPLETED BY PARENTS (before appointment:

HEALTH HISTORY (*Please indicate* age and/or year on past and current medical conditions):

1.	Anemia	9.	Heart Disease
2.	Asthma	10.	Hernia
3.	Chickenpox	11.	Mumps
4.	Convulsions/Seizure	12.	Rheumatic Fever
5.	Diabetes	13.	Skin Disorder
6.	Measles	14.	Tuberculosis
7.	Hay Fever	15.	Vision
8.	Hearing	16.	Other

Please complete and provide additional information at the back:

Head Injuries:	Yes	No	Year:	Results:
Previous hospitalization:	Yes	No	Year:	Results:
Allergies: Yes No (please	list):			
Any specific reaction(s):				
<u> </u>	Yes	No		
Reason/Diagnosis:				
Special medical needs:	Yes	No	(specify):	
Special inecical needs.	105	110	(speeny).	
Disability: Yes	No (specify):		
Prosthesis: Yes	No (specify):		
Classes Ves	No	(anagify).		
Glasses. Tes	INO	(specify).		
Hearing Aid: Yes	No	(specify):		
			0.11	
1.1	exercis	ing becaus	e of dizziness or pass	sing out during exercise?
	(-inal have	farran an aguahina an	alla aftan ayanaisa 2
	i (whee	zing), nay	rever or coughing spo	ens after exercise?
	oken bo	ne had to	wear a cast or had a	n injury to any joint?
	OKCII OC	ine, maa to	vicar a cast, or nad a	in injury to any joint.
	rv of co	ncussion (getting knocked out)	?
Yes No	J == •		.6	•
	Previous hospitalization: Allergies: Yes No (please Any specific reaction(s): Currently taking medication: Name of medication(s): Reason/Diagnosis: Special medical needs: Disability: Yes Prosthesis: Yes Glasses: Yes Hearing Aid: Yes Has the student ever stopped Yes No Does the student have asthmatyes No Has the student ever had a broyes No Does the student have a history and the student have a h	Previous hospitalization: Yes Allergies: Yes No (please list): Any specific reaction(s): Currently taking medication: Yes Name of medication(s): Reason/Diagnosis: Special medical needs: Yes Disability: Yes No (Prosthesis: Yes No (Glasses: Yes No (Hearing Aid: Yes No Has the student ever stopped exercis Yes No Does the student have asthma (whee Yes No Has the student ever had a broken boyes No Does the student have a history of co	Previous hospitalization: Yes No Allergies: Yes No (please list): Any specific reaction(s): Currently taking medication: Yes No Name of medication(s): Reason/Diagnosis: Special medical needs: Yes No (specify): Prosthesis: Yes No (specify): Glasses: Yes No (specify): Hearing Aid: Yes No (specify): Has the student ever stopped exercising becaus Yes No Does the student have asthma (wheezing), hay Yes No Has the student ever had a broken bone, had to Yes No Does the student have a history of concussion (Previous hospitalization: Yes No Year: Allergies: Yes No (please list): Any specific reaction(s): Currently taking medication: Yes No Name of medication(s): Reason/Diagnosis: Special medical needs: Yes No (specify): Disability: Yes No (specify): Prosthesis: Yes No (specify): Glasses: Yes No (specify): Hearing Aid: Yes No (specify): Has the student ever stopped exercising because of dizziness or pass Yes No Does the student have asthma (wheezing), hay fever or coughing sp Yes No Has the student ever had a broken bone, had to wear a cast, or had a Yes No Does the student have a history of concussion (getting knocked out)

30.	Has the student ever suffered a heat-related illness (heat stroke)?		
	Yes No		
31.	Does the student have a chronic illness or see a doctor regularly for any	particular problem?	
	Yes No		
32	Any medical reason why this child should NOT participate in Physical	Education or related activities?	
	Yes No		
Plea	lease give details on any "Yes" answer(s) from the above health history.		
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NOTE:	TE: It is important to notify the School Health Counselor or School Admit	nistrator of any changes in the]
NOTE:	<u>TE</u> : It is important to notify the School Health Counselor or School Admin health status of this student.	nistrator of any changes in the]
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	health status of this student.		J. AMC.
	health status of this student.		TABLE.
	health status of this student.		Машс.





PART II: PHYSICAL EXAMINATION (TO BE COMPLETED BY HEALTH CARE PRACTITIONER):

Г-Р-R-ВР:/	/	/	_				
Height: Vis	ion:	Right <u>20/</u>	Corrected:	Yes	No	Hearing:	Right
Weight:BMI:	_	Left 20/	Contacts:	Yes	No		Left
Complete Feel Item	Norn	nal					
Complete Each Item Below		No Des	scribe Findings	<mark>if Abnorn</mark>	nal or	Reason for	not Examining
General appearance							
Skin							
Hair							
Nails							
Eyes: External							
(Pupil/Cornea)							
Optic Fundus							
Auditory Acuity							
Muscle Balance							
Ears: External							
Auditory Acuity							
Tympanic Membrane							
Nose							
Mouth							
Pharynx							
Larynx							
Speech							
Teeth/Gums							
Neck/Lymph/larynx							
Cardiovascular							
Respiratory							
Gastro Intestinal							
Genital-Urinary							
Muscular Skeletal							
Scoliosis Screening							
Neurological Impressions							
Nutritional Status							
Behavior during							
Examination							
Other							
Hemoglobin: Other Test:			<mark>ABORATORY</mark> Hem				e:
Other Test:		Res	ult:			_ Da	te:
This child is physically fit Yes No	to partici	ipate in physic	cal education and	d/or athleti	ic even	ts and relate	ed activities.
Diagnosis/Findings		Treatmen	t		Follo	w up plan	
Name of Health Care Pro	ovider (]	Print)	Sią	gnature			 Date
Clinic Name & Phone Nu	 ımber						