PHYSICAL EXAMINATION RECORD

(Must be filled out by a medical professional)

Kindergarten (   )　　Seventh Grade (   )　　Other (   )

Name________________________________ Date of Birth ________________ Sex ________

Parents/ Guardians ____________________________________ Phone __________________

Address ____

Health History:

Does your student have or has he/she had any of the following:

Diabetes _____________　Seizures _____________　Kidney Disease _______________

Asthma______________　Fainting Episodes _______　Vision Problems ______________

Allergies_____________　Hearing Loss__________　Disabilities________________

Surgeries or hospitalizations____

Any health problem (s) you are concerned about_______________________________________

PHYSICAL EXAM

Height ___________　Eyes___________　Heart____________

Weight___________　Ears____________　Lungs___________

B.P.______________　Mouth__________　Abdomen_________

Pulse_____________　Nose___________　Muscles_________

Neurological_______　Throat__________　Bones___________

Skin/Scalp_________　Tonsils_________　Other____________

The following are to be done as needed or if indicated: Temp. ________ HCT. _______________

Urine (Protein/Sugar) _______________

Vision (required for Kindergarten)　Both Eyes_____/_____　RT _____/_____　LT _____/_____

General condition ____

Limitations or restrictions: ____

Recommendations or follow-up needed: ____

Signature:____　Date:________________