PHYSICAL EXAM: ASSESSMENT

Height
Weight
General Physical Development
Posture
Eyes Pupils Conjunctivitis Strabismus
Ears Drums Canals
Nose
Mouth Tongue Throat
Lymph Nodes
Thyroid
Lungs Thorax
Heart Pulse and rhythm
Blood Pressure
Abdomen
Hernia
Genitalia
Feet
Skin
Nervous System
Laboratory Reports
Scoliosis
Other:

STUDENT NAME: _____

Birthday: _____ **Grade:** _____

Male ☐ Female ☐

MEDICAL HISTORY, EXAMINATION AND RECOMMENDATIONS

HISTORY OF IMMUNIZATIONS:

	Date				
Immunizations	**First**	**Second**	**Third**	**Fourth**	**Fifth**
DTP					
DTaP					
Td					
Tdap					
OPV					
IPV					
MMR					
HEP A					
HEP B					
Varivax (Ckn pox)					
TB/PPD					
HIB (H-flu)					

Chicken Pox Disease Date:

Hearing:

R

L

Allergies Requires Epi Pen YES ☐ NO ☐

- ☐ Food
- ☐ Medication
- ☐ Bee
- ☐ Other

Asthma	YES ☐	NO ☐
Epilepsy or Seizures	YES ☐	NO ☐
Heart Condition	YES ☐	NO ☐
Orthopedic Problems	YES ☐	NO ☐
Restricted Diet	YES ☐	NO ☐

CAN STUDENT PARTICIPATE IN REGULAR PHYSICAL EDUCATION PROGRAM?

YES ☐ NO ☐

If "No," please state restrictions:

.....

What adaptation is required?

.....

OTHER RECOMMENDATIONS AND REMARKS:

.....

.....

HEALTH HISTORY and DIAGNOSIS:

1. .....
2. .....
3. .....

LIST MEDICATIONS, DOSAGE & TIME GIVEN:

1. .....
2. .....
3. .....
4. .....

Physician's Address:

Physician's Telephone #:

PHYSICIAN SIGNATURE **Date**

►