

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> da 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  
Cell Phone Number

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

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 THE 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 his/her mouth? Yes: \_\_\_ No: \_\_\_

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

In the event of a medical emergency warranting immediate medical care, EMS (911) will be called and parents will be responsible for all incurred expenses.

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: \_\_\_\_\_

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)