Department of Education
PHYSICAL EXAM FORM
ELEMENTARY

School: _____

Student:		**DOB:**
☐ Male ☐ Female	Grade:	HR:
Home Address:		
Father/Guardian:	**Mother**/Guardian:	
Place of work:	Place of work:	
Phone: Home: Work:	Phone: Home: 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 1200-020.

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:

17.	Head Injuries: ☐ Yes ☐ No	Year:	Results:
18.	Previous hospitalization: ☐ Yes ☐ No	Year:	Results:
19.	Allergies: ☐ Yes ☐ No (please list) : Any specific reaction(s):		
20.	Currently taking medication: ☐ Yes ☐ No		
	Name of medication(s):		
	Reason/Diagnosis:		
21.	Special medical needs: ☐ Yes ☐ No (specify):		
22.	Disability: ☐ Yes ☐ No (specify):		
23.	Prosthesis: ☐ Yes ☐ No (specify):		
24.	Glasses: ☐ Yes ☐ No (specify):		
25.	Hearing Aid: ☐ Yes ☐ No (specify):		
26.	Has the student ever stopped exercising because of dizziness or passing out during exercise? ☐ Yes ☐ No		
27.	Does the student have asthma (wheezing), hay fever or coughing spells after exercise? ☐ Yes ☐ No		
28.	Has the student ever had a broken bone, had to wear a cast, or had an injury to any joint? ☐ Yes ☐ No		
29.	Does the student have a history of concussion (getting knocked out)? ☐ Yes ☐ No		

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
Please give details on any **"Yes"** answer(s) from the above health history.	

NOTE: It is important to notify the School Health Counselor or School Administrator of any changes in the health status of this student.

_____ _____

Parent/Guardian Print & Signature **Date**

Remarks:

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

T-P-R-BP: _____/_____/_____/_____

Height: _____ **Vision:** Right 20/____ Corrected: ☐ Yes ☐ No **Hearing:** Right _____

Weight: _____**BMI:**_____ Left 20/_____ Contacts: ☐ Yes ☐ No Left _____

Complete Each Item Below	Normal		Describe Findings if Abnormal or Reason for not Examining
	Yes	No	
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			

PART III: LABORATORY TESTING (If Required)

Hemoglobin: _____ Date: _____ Hematocrit: _____ Date: _____
Other Test: _____ Result: _____ Date: _____

This child is physically fit to participate in physical education and/or athletic events and related activities.
Yes No

Diagnosis/Findings	Treatment	Follow up plan

_____
Name of Health Care Provider (Print) **Signature** **Date**

_____
Clinic Name & Phone Number