



ANNUAL PHYSICAL EXAM FORM

To be completed by a parent/guardian. Please print all information.

Student _____ Date of Birth _____ Grade _____

Please circle gender: male female

MEDICAL HISTORY

Allergies _____ Food allergy _____ Illness _____

Surgeries _____ Accident/ Injury _____

Is student taking **any** medication on a routine basis? Yes _____ No _____

List all medication : _____

Is student allergic to any medication? Yes _____ No _____ Please list and describe reaction: _____

Has student consulted with a specialist in the past 5 years?

Yes _____ No _____ If yes, please describe nature of condition: _____

This section to be completed by examining physician.

PHYSICIAN EXAMINATION :

Height _____ Weight _____ BMI _____ Blood Pressure _____ Pulse _____

	Normal	Abnormal		Normal	Abnormal
General Appearance			Cardiovascular		
Skin			Gastrointestinal		
Eyes			Genito-urinary		
Ears/Nose/Throat			Neurological		
Mouth/Dental Assessment			Developmental Screening		
Muscular			Nutritional Assessment		
Skeletal			Respiratory		

Are there concerns for this student's health?

Is the student capable of physical activity and participation in a competitive athletic program? _____ Yes _____ No

Are there any sports in which this student should not participate? _____

Are there any restrictions or activity limitations? _____

SCREENING TESTS:

Tuberculin test: Date _____ Positive _____ Negative _____ CSR date (if pos.): _____

Vision: Right 20/_____ Corrected to 20/_____ Left 20/_____ Corrected to 20/_____

RECENT IMMUNIZATION DATES:

Varicella: dose one _____, dose two _____ History of the disease: _____

Td/Dtap: _____ MMR: _____ HEP B: _____, _____, _____ Polio: _____ HEP A _____, _____

Pneumonia (PCV7) _____

Results of the physical exam completed by me on this date indicate that the individual named above is in good health.

Any problems to the contrary have been noted above.

Date _____ Examining Physician Signature _____

Physician's Name _____ Phone _____