

SCHOOL CITY OF WHITING

PHYSICAL FORM

SCHOOL YEAR

2023-2024

Student Name _____ Date of Birth _____ Grade _____

Age _____ Sex M _____ F _____ Height _____ Weight _____ B/P _____

T.B. Test: (If at risk) Type _____ Date _____ Result _____ Date Read _____

Chest X-ray _____ Treatment _____

Sickle Cell Anemia Test (if needed) _____

Urinalysis _____

Hemoglobin _____

IMMUNIZATIONS: (Must show Month/Day/Year)

DTaP/DTP/DT _____

TDaP _____

TD _____

Polio (IPV) _____

Measles _____

Rubella _____

Mumps _____

Hepatitis A _____

Hepatitis B _____

Hib _____

Varicella _____

Meningococcal _____

< OR > Had chicken pox disease at age _____ Month _____ Year _____
(Dr.'s signature for verification of chicken pox disease } _____)

Covid19 Vaccine

(Please check if Normal or Abnormal. If abnormal describe below)

	Normal	Abnormal		Normal	Abnormal
Physical Development	_____	_____	Throat	_____	_____
Nutritional	_____	_____	Lungs	_____	_____
Skin	_____	_____	Heart	_____	_____
Hair and Scalp	_____	_____	Abdomen	_____	_____
Eyes and Vision	_____	_____	Extremities	_____	_____
Ears and Hearing	_____	_____	Orthopedic	_____	_____
Nose	_____	_____	Scoliosis	_____	_____

Describe any abnormal findings or any instructions for student's specific needs _____

PHYSICAL FITNESS EVALUATION: (Please check one of these recommendations)

- I recommend the regular school P.E. program (includes running, basketball, tennis, etc.): _____
- *I recommend modified P.E. activity (includes ping-pong, shuffleboard, throwing, etc.): _____
- Specify degree and reason _____
- *I recommend exclusion from Physical Education: _____

(REASON MUST BE GIVEN)

*Recommendation for modified activity or exclusion is effective for the current school year only, unless specified below.
Comments and Recommendations _____

Physician's Signature _____ Date _____

Physician's Name (please print) _____