CAPE ELIZABETH SCHOOLS
PHYSICAL EVALUATION FORM

Please send/fax all information to the HEALTH OFFICE at:

☐ High School	☐ Middle School	☐ Pond Cove Elementary
345 Ocean House Rd	14 Scott Dyer Rd	12 Scott Dyer Rd
Cape Elizabeth ME 04107	Cape Elizabeth ME 04107	Cape Elizabeth ME 04107
Fax 207.767.8050	Fax 207.767.0832	Fax 207.799.8171

Date of Physical Exam: ____________________

Name: ______________________________ Sex: _____ Age: ______ DOB: ____________ Grade: ______

Pulse: ______________ BP: ___________ Height: _________ Weight: __________ BMI: _________

Medications: ____

Allergies (foods, insects, drugs, latex): ____

Emergency Plans (Allergy, Seizure, Diabetes, Asthma, etc.): ______________________________

***** Please attach copies of any plans related to chronic health conditions.*****

History:	N	Abnormal	Physical Examination:	N	Abnormal
Asthma/Respiratory			Appearance (Marfan Stigmata, other)		
ADD/ADHD			Eyes/Ears/Nose/Throat		
Behavioral Issues			Vision		
Cardiovascular (Murmurs, etc.)			Hearing		
Concussion			Speech		
Developmental Issues			Lymph Nodes		
Dental Concerns			Heart		
Endocrine/Thyroid			Peripheral pulses		
Fractures			Lungs		
Gastrointestinal			Abdomen		
Gynecologic History			Genitourinary		
Hospitalizations			Gynecologic		
Immune System			Skin (Lesions, Rashes)		
MRSA			Neurologic		
Nephrotic Conditions			Musculoskeletal		
Seizure History			Other		
Surgery					
Other					

Chronic Medical Conditions: ____

____

Behavioral/Mental Health Concerns: ____

____

Immunizations UTD: Y ☐ N ☐ *****Please attach most recent Immunization record.*****

Labs (Hemoglobin/HCT, TB screen, etc.): ____

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics/physical education.

____**CLEARED WITHOUT RESTRICTIONS**

____Cleared **AFTER** further evaluation or treatment for ___________________________________

____Cleared for **Limited Participation** – Reason(s) and Explanation___________________________

____**NOT CLEARED FOR PARTICIPATION** – Reason(s) and Explanation ______________________

_________________________________ *Health Care Provider's name (print)*

_________________ *Date*

_________________________________ *Health Care Provider's signature*

_________________ *Phone*

_________________ *Fax*