STUDENT'S PHYSICAL EXAMINATION REPORT
Physician's Report

Please return this completed form to the office by the 1st day of attendance.

Student's Name_____**Sex**_____**Birthdate**_____

Height:_____ **Weight**_____ **Blood Pressure**_____/_____

Disability of Hearing_____ **Extent**_____ **Corrected**_____

Visual Acuity: R20/_____**L20/**_____**Corrected R20/**_____**L20/**_____**Diabetes**_____

Known Allergies_____

Asthma/Bronchitis_____**Seizure Disorder**_____**Scoliosis**_____

	Normal	Abnormal or Comments
EYES	_____	_____
EARS	_____	_____
NOSE	_____	_____
THROAT	_____	_____
TEETH	_____	_____
SCALP AND SKIN	_____	_____
HEART	_____	_____
LUNGS	_____	_____
ABDOMEN	_____	_____
POSTURE	_____	_____
ORTHOPEDIC AND FEET	_____	_____
NERVOUS SYSTEM	_____	_____
NUTRITION	_____	_____
GLANDS	_____	_____
THYROID	_____	_____

PHYSICIAN'S COMMENTS AND/OR REFERRALS:_____
_____
_____

Have arrangements been made for further necessary medical attention? Yes_____ **No**_____

Is pupil capable of carrying a full program of school work ? Yes_____ **No**_____

Should this student have any restriction on physical education, athletics or other activity?
No_____**Yes**_____**Explain**_____

Are there any recommendations for follow-up, specific medical or surgical care? No____**Yes**_____
Explain_____

PHYSICIAN'S SIGNATURE:_____**DATE:**_____

PHYSICIAN'S ADDRESS:_____**PHONE:**_____