

**THIS FORM MUST BE RETURNED BEFORE SCHOOL STARTS**

School District of Seneca  
Seneca, Wisconsin

**PHYSICAL EXAMINATION MUST BE COMPLETED BY A PHYSICIAN**

Name of Pupil \_\_\_\_\_ Grade \_\_\_\_\_  
Name of Parents \_\_\_\_\_  
Address \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Hemoglobin(optional): \_\_\_\_\_

Physical findings that are significant to school:  
Please check if abnormal and comment below.

Allergies: \_\_\_\_\_

Skin: \_\_\_\_\_

EENT: \_\_\_\_\_

Vision: \_\_\_\_\_

Heart & Lungs: \_\_\_\_\_

GU: \_\_\_\_\_

General Nutrition: \_\_\_\_\_

Orthopedics: \_\_\_\_\_

Blood: \_\_\_\_\_

Behavior: \_\_\_\_\_

Neurological: \_\_\_\_\_

Speech: \_\_\_\_\_

Other: \_\_\_\_\_

Remarks:

Recommendations to the school:

1. Is this pupil capable of carrying a full program of school work? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Should there be any restrictions of physical activities? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Physician \_\_\_\_\_ Date \_\_\_\_\_