Physical Assessment Form

2017-18

Re-enrolling students must submit annually, on the anniversary of their last physical exam.
New students must submit prior to their first day of classes.

Student Name: _____

Grade: _____ (2017-2018) Birth Date: _____ ☐ Returning student ☐ New Student

To be completed by the **Physician:**

Date of Exam: _____

Height: _____ inches
Weight: _____ lbs.
BP: ____/____

Scoliosis Screening: ☐ Pass ☐ Fail
Hearing Test: ☐ Pass ☐ Fail
Vision Test: ☐ Pass ☐ Fail

Allergies: _____

☐ Epinephrine is prescribed for anaphylactic reaction and must be available at school*.

History of anaphylaxis: ☐ Yes ☐ No History of Asthma: ☐ Yes ☐ No

Medications taken on a regular basis: _____

Medications required at school*: _____

*Please complete the form "**Physician Order for Prescription Medication in School**"

Current Health Problems: (please check all that apply)

☐ ADHD-Inattentive	☐ Depression	☐ Musculoskeletal problem
☐ ADHD-Hyperactive	☐ Developmental delay	☐ Neurological problem
☐ Anxiety	☐ Diabetes	☐ Respiratory problem
☐ Asthma	☐ Gastrointestinal problem	☐ Seizures or convulsions
☐ Athletic injury	☐ Hearing problem	☐ Skin problem
☐ Bleeding disorder	☐ Headaches	☐ Speech problem
☐ Cardiac problem	☐ History of Fainting	☐ Surgical history
☐ Concussion Date: _____	☐ Liver or Kidney problem	☐ Vision problem
☐ Dental problem	☐ Migraines	☐ Other _____

Please tell us more about any health problems you have checked. _____

_____

This student is current with all recommended immunizations. ☐ Yes ☐ No

Please attach an immunization record for New Students and/or Students entering Kindergarten, 6th, 7th, or 11th grades

☐ Cleared for full participation

☐ Cleared with the following restrictions: _____

☐ May not participate (indicate reason): _____

Physician Signature: _____ Signature Date: _____

Office Stamp:

RETURN TO:
SCHOOL HEALTH CENTER: 450 LANCASTER AVENUE • HAVERFORD, PENNSYLVANIA 19041
(610) 642-3020 X1994 AND X1234 • NURSE'S FAX: (610) 896-0759