

THE GREEN VALE SCHOOL

PHYSICAL EXAMINATION

STUDENT \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades K, 2, 4, 7 and 10 will be examined by the school physician if no report is received. \*An annual physical examination is required for participation in interscholastic sports. (\*Both sides must be completed.)

- 1. BP \_\_\_\_\_ Pulse \_\_\_\_\_
2. Height \_\_\_\_\_ Weight \_\_\_\_\_
Body Mass Index: \_\_\_\_\_
Weight Status Category ( BMI Percentile )
3. Urinalysis \_\_\_\_\_
4. Heart \_\_\_\_\_
5. Breasts \_\_\_\_\_
6. Lungs \_\_\_\_\_
7. Eyes R \_\_\_\_\_ L \_\_\_\_\_
8. Visual Diagnosis \_\_\_\_\_
9. Ears: Otitic \_\_\_\_\_
Audiometric \_\_\_\_\_
P.E. tubes Yes \_\_\_\_\_ No \_\_\_\_\_
10. Speech \_\_\_\_\_
11. Nose \_\_\_\_\_
12. Throat \_\_\_\_\_
13. Tonsils \_\_\_\_\_
14. Teeth and gums \_\_\_\_\_
15. Skin \_\_\_\_\_
16. Glands (cervical, thyroid, other) \_\_\_\_\_
17. Nervous system \_\_\_\_\_
18. Hernia \_\_\_\_\_
19. Genitourinary \_\_\_\_\_
20. Tanner I. II. III. IV. V.
21. Orthopedic: scoliosis: \_\_\_\_\_ positive \_\_\_\_\_ negative
posture \_\_\_\_\_ feet \_\_\_\_\_
structural defects \_\_\_\_\_
22. Abdomen \_\_\_\_\_

SURGERIES: \_\_\_\_\_

SIGNIFICANT ILLNESSES / INJURIES: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM

Full Activity \_\_\_\_\_ Restriction \_\_\_\_\_ Recommendation \_\_\_\_\_

CURRENT MEDICATIONS (please list all medications and dosages):

\_\_\_\_\_

IMMUNIZATIONS (please fill in or attach record of immunization)

PROCEDURES / TESTS

DPT or DTaP \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
(3 required)

Td or DT Booster \_\_\_\_\_

Tdap \_\_\_\_\_

Polio (OPV or IPV) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
(3 required)

PCV \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

MMR \_\_\_\_\_ / \_\_\_\_\_
(2 measles required)

Varicella \_\_\_\_\_ / \_\_\_\_\_

HIB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Hep B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
(3 required)

Other \_\_\_\_\_

TB Screening \_\_\_\_\_

Chest X-ray \_\_\_\_\_

Lead Screening \_\_\_\_\_

Sickle Cell Test \_\_\_\_\_

Signature of Examining Physician

Date

Print Name

Physician's Address & Phone #
(PLEASE STAMP)

