ANNUAL PHYSICAL EXAM FORM

To be completed by a parent/guardian. Please print all information.

Student __________________________ Date of Birth __________________________ Grade _________________

Please circle gender:  male    female

MEDICAL HISTORY

Allergies ___________________________ Food allergy _____________________ Illness _________________________

Surgeries _______________________________________________ Accident/ Injury ____________________________

Is student taking any medication on a routine basis? Yes _____ No _____

List all medication:

____________________________________________________________________________________________

Is student allergic to any medication? Yes _____ No _____ Please list and describe reaction:

________________________________________________________________________________________________

Has student consulted with a specialist in the past 5 years?  Yes _____ No _____ If yes, please describe nature of condition:

________________________________________________________________________________________________

This section to be completed by examining physician.

PHYSICIAN EXAMINATION:

Height_________ Weight ___________ BMI _______ Blood Pressure_____________ Pulse ______________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Cardiovascular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Genito-urinary</td>
<td></td>
</tr>
<tr>
<td>Ears/Nose/Throat</td>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Mouth/Dental Assessment</td>
<td>Developmental Screening</td>
<td></td>
</tr>
<tr>
<td>Muscular</td>
<td>Nutritional Assessment</td>
<td></td>
</tr>
<tr>
<td>Skeletal</td>
<td>Respiratory</td>
<td></td>
</tr>
</tbody>
</table>

Are there concerns for this student’s health?

________________________________________________________________________________________________

Is the student capable of physical activity and participation in a competitive athletic program? _____ Yes _____ No _____

Are there any sports in which this student should not participate?

________________________________________________________________________________________________

Are there any restrictions or activity limitations?

________________________________________________________________________________________________

SCREENING TESTS:

Tuberculin test: Date _______________ Positive ______ Negative _______ CSR date (if pos.): ____________

Vision: Right 20/________ Corrected to 20/_________ Left 20/___________ Corrected to 20/___________

RECENT IMMUNIZATION DATES:

Varicella: dose one _______________, dose two _______________ History of the disease: ______________

Td/Dtap: _________ MMR: _______ HEP B: _______ HEP A: _______ Polio: _______ HEP A: _______ ______

Prevnar (PCV7) pneumonia _____________

Results of the physical exam completed by me on this date indicate that the individual named above is in good health. Any problems to the contrary have been noted above.

Date _________________ Examining Physician Signature _________________________________________________

Physician’s Name ____________________ _____________________________ Phone _______________

Last updated: 6/4/2012