



**Private or School  
PHYSICAL EXAMINATION  
OF SCHOOL AGE STUDENT**

**PARENT / GUARDIAN / STUDENT:**  
Complete page one of this form before  
student's exam. Take completed form to  
appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_  
Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)

Medicines  Pollens  Food  Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO	GENITOURINARY: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____			29. Had groin pain or a painful bulge or hernia in the groin area?		
2. Ever stayed more than one night in the hospital?			30. Had a history of urinary tract infections or bedwetting?		
3. Ever had surgery?			31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
4. Ever had a seizure?			<b>DENTAL:</b>	YES	NO
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?			32. Has the student had any pain or problems with his/her gums or teeth?		
6. Ever become ill while exercising in the heat?			33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
7. Had frequent muscle cramps when exercising?			<b>SOCIAL/LEARNING: <i>Has the student...</i></b>	YES	NO
<b>HEAD/NECK/SPINE: <i>Has the student...</i></b>	YES	NO	34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
8. Had headaches with exercise?			35. Been bullied or experienced bullying behavior?		
9. Ever had a head injury or concussion?			36. Experienced major grief, trauma, or other significant life event?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?			38. Been worried, sad, upset, or angry much of the time?		
12. Ever been unable to move arms or legs after being hit or falling?			39. Shown a general loss of energy, motivation, interest or enthusiasm?		
13. Noticed or been told he/she has a curved spine or scoliosis?			40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?			41. Used (or currently uses) tobacco, alcohol, or drugs?		
15. Been prescribed glasses or contact lenses?			<b>FAMILY HEALTH:</b>	YES	NO
<b>HEART/LUNGS: <i>Has the student...</i></b>	YES	NO	42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited diseases/syndromes <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
16. Ever used an inhaler or taken asthma medicine?			43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____			44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?			45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?			<b>QUESTIONS OR CONCERNS:</b>	YES	NO
20. Had discomfort, pain, tightness or chest pressure during exercise?			46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		
21. Felt his/her heart race or skip beats during exercise?					
<b>BONE/JOINT: <i>Has the student...</i></b>	YES	NO			
22. Had a broken or fractured bone, stress fracture, or dislocated joint?					
23. Had an injury to a muscle, ligament, or tendon?					
24. Had an injury that required a brace, cast, crutches, or orthotics?					
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?					
26. Had joints that become painful, swollen, feel warm, or look red?					
<b>SKIN: <i>Has the student...</i></b>	YES	NO			
27. Had any rashes, pressure sores, or other skin problems?					
28. Ever had herpes or a MRSA skin infection?					

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes  No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: ( ) inches				
Weight: ( ) pounds				
BMI: ( )				
BMI-for-Age Percentile: ( )%				
Pulse: ( )				
Blood Pressure: ( / )				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION  
 (Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

**HEALTH CARE PROVIDERS:** Please photocopy immunization history from student's record – OR – insert information below.

**IMMUNIZATION EXEMPTION(S):**

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
<b>Other Vaccines: (Type and Date)</b>					