***Health Examination by Physician***

To be completed by your primary physician:

Name of Student: _____ Birthdate: _____

Parents: _____ Address: _____

Vision Acuity: _____ Hearing: Audiogram: _____

Ht. _____ Wt. _____ BP _____

| | Normal | Abnormal | Not Done | Comments |
|---|---|---|---|---|
| **Skin** | | | | |
| **Head** | | | | |
| **EENT** | | | | |
| **Respiratory** | | | | |
| **Heart** | | | | |
| **Abdomen** | | | | |
| **Neuromuscular** | | | | |
| **Spine** | | | | |
| **Extremities** | | | | |
| **Genitalia** | | | | |
| | | | | |

Please describe any physical disabilities, emotional or behavioral concerns that may be helpful for the nurse to know about when providing care in this child's ability to learn:

_____

List any Significant Illnesses, Accidents or Operations:

_____

Preexisting Health concerns (i.e. diabetes, allergies, asthma, epilepsy):

_____

List any immunizations given today: _____

Is the child on any routine or long term medications? _____ No _____ Yes

List medications: _____

Is this student capable of carrying a full program of school work including physical education?

_____ No _____ Yes If no, please explain _____

Physician: _____ Address: _____ Date: _____