PHYSICAL EXAMINATION

General Appearance_____ Height_____ Weight_____
Nutrition_____ Skin_____
Skeletal Development_____ Scoliosis_____
Lymph Nodes_____

HEAD
Scalp_____
Eyes_____
Ears_____ Hearing_____
Nose_____
Throat/Tonsils_____

Vision
** For kindergarten students, please use the attached form.*

	R	L
1. Without correction	_____	_____
2. With correction	_____	_____

NECK Thyroid_____

CHEST Heart_____ Size_____ Rate_____ Rhythm_____ BP_____

ABDOMEN Viscera_____ Liver_____ cm_____
Her_____ Genitals_____

EXTREMITIES Upper_____ Lower_____

NEUROLOGICAL _____

LAB TESTS Urinalysis_____ Hematocrit_____
Other_____

RECOMMENDATIONS
Physical Activity (circle one): Unrestricted Moderate Minimum
Remarks and Suggestions:

_____ _____ _____
Printed Name/Clinic *Signature of M.D./P.A./A.P.R.N.* *Date of Exam*

ESU #8 SCHOOL HEALTH PHYSICAL FORM

Name_____ **School**_____

Address_____ **Date of Birth**_____

Parent or Guardian_____ **Phone (home)**_____ **(cell)**_____

Immunizations	Month/Day/Year	Given By:
DTaP/DTP/TD (Diphtheria-Tetaus-Pertussis)	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
Polio (IPV, OPV)	1.	
	2.	
	3.	
	4.	
	5.	
MMR (Measles-Mumps-Rubella)	1.	
	2.	
Hepatitis B	1.	
	2.	
	3.	
Varicella	1.	
	2.	
HIB	1.	
	2.	
	3.	
Other		

Medical History	Yes	No	Comments:
Allergies			
Asthma			
Diabetes			
Glasses/Vision Difficulties			
Head Injury			
Hearing Loss or Difficulties			
Heart Problems			
Orthopedic Problems			
Seizures			
Surgery			
Current Medications / Dose / Reason:			

I give my consent to share this information with school personnel. *Parent Signature*_____ *Date*_____