PHYSICAL EXAMINATION FORM

Student's Name_____Grade_____ Date of Birth_____

Parent/Guardian_____ Address_____

Telephone_____ School_____

Please check the appropriate box	**If yes, describe recommendation for School personnel:**
Is there any defect of: Vision Yes ☐ No ☐ Hearing Yes ☐ No ☐ Speech Yes ☐ No ☐	
Does student have any health conditions that limits: Classroom activity Yes ☐ No ☐ Homework Yes ☐ No ☐ Physical education Yes ☐ No ☐ Competitive athletics Yes ☐ No ☐	
Does this student have any health condition that may require a special health plan or may result in a school emergency such as: Anaphylaxis Yes ☐ No ☐ Asthma Yes ☐ No ☐ Diabetes Yes ☐ No ☐ Migraines Yes ☐ No ☐ Seizures Yes ☐ No ☐ Other:_____	
Does this student receive any routine medication during the school day? Yes ☐ No ☐ Please list:_____ _____	Please Complete School Medication Form
Does this student exhibit any abnormality of: Growth Yes ☐ No ☐ Nutrition Yes ☐ No ☐ Maturation Yes ☐ No ☐	
For Kindergarten Students, please complete and attach immunization card. Attached ☐	Please check reverse side for special DTP requirement for Kindergarten students.

Signature of Physician _____Date_____

Printed/Typed Name Physician_____Phone:_____

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