

**PHYSICAL EXAM FOR SCHOOL ENTRY**

**Nome Elementary School**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Home address \_\_\_\_\_ Home phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_

**Part I- HISTORY: To be completed and signed by child's parent/guardian.**

**To Parent/Guardian:** Please check answers to questions 1 through 21 below in the column on the left.

*(Please explain any "Yes" answers in the space provided below.)*

1. Yes  No  Any current illness?
2. Yes  No  Allergy ((food, drug, latex, airborne, bee sting, other)
3. Yes  No  Asthma or breathing problems
4. Yes  No  Attention-Deficit/Hyperactivity Disorder
5. Yes  No  Bladder/Bowel problems
6. Yes  No  Dental problems
7. Yes  No  Developmental problems
8. Yes  No  Diabetes
9. Yes  No  Head or spinal injury
10. Yes  No  Hearing problem (ear tubes, hearing aids)
11. Yes  No  Heart problems
12. Yes  No  Hospitalizations, operation, or major illness
13. Yes  No  Loss of consciousness
14. Yes  No  Medications
16. Yes  No  Muscle problems
17. Yes  No  Seizure
18. Yes  No  Speech problems
19. Yes  No  TB test positive
20. Yes  No  Vision problems (glasses, contacts)
21. Yes  No  My child is healthy and has no health concerns

**To Parent/Guardian:** Please explain any "Yes" answers from above.

\_\_\_\_\_

\_\_\_\_\_

List all prescription, over-the-counter, and herbal medications your child takes regularly or occasionally: \_\_\_\_\_

\_\_\_\_\_

**\*A Long-Term Medication form must be completed by your healthcare provider if your child needs medication at school.**  
**\*Parent must provide emergency medications such as Epi-pen, inhaler, glucagon, and diastat if needed in school, Immunization record and TB test if done must be provided at school.**

X \_\_\_\_\_  
 Parent / Guardian Signature

**Part II- PHYSICAL EXAMINATION: To be completed by Licensed Physician (MD or DO), Advanced Nurse Practitioner or Physician's Assistant only.**

**SCREENING RESULTS:** Male  Female   
 Height: \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs. BMI%: \_\_\_\_\_  
 B/P: \_\_\_\_\_  
 Vision - w/o Glasses: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Both 20/\_\_\_\_  
 Vision - With Glasses: Right 20/\_\_\_\_ Left 20/\_\_\_\_ Both 20/\_\_\_\_  
 HEARING - Right: Passed  Failed  Referred   
 HEARING - Left: Passed  Failed  Referred

	NORMAL	ABNORMAL	TREATED	REFERRED TO
Eyes				
Ears				
Nose				
Throat				
Teeth				
Neck				
Lungs				
Heart				
Abdomen				
Genitalia				
Posture				
Joints				
Skin				
Neurological				
Behavioral				
Emotional				

**IMMUNIZATION STATUS:**  Up-to-Date  Waiting Period  Exemption

**PPD SKIN TEST:** Date given \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_ mm

**This child has the following problems that may impact school success**

- Vision  Hearing  Speech/Language  Physical  
 Social/Behavioral  Cognitive Specify: \_\_\_\_\_

This child has a health condition that may require emergency action at school, e.g. seizures, allergies, asthma. Specify \_\_\_\_\_

This child may participate fully in school activities including physical education.

This child may participate in school activities including physical education with the following restriction/adaptation. Specify: \_\_\_\_\_

**Healthcare Provider Signature & Title: \_\_\_\_\_ Date \_\_\_\_\_**

**Printed Name or stamp:** \_\_\_\_\_