



Dear Parent or Guardian,

The maintenance of optimum health of your child is part of the school health program. As part of that program, school policy requires that **all** children entering Kindergarten, and any new pupils receive a pre-entrance physical examination. A physical examination is also required for all pupils in grades 2, 5 and 8.

For your convenience, a physical examination form is attached and is to be completed by your family physician. The pre-entrance (Kindergarten and all new pupils) physical form must be completed and signed by your physician and returned to the school nurse by the **first day of school**. All other pupils (grades 2, 5 and 8) must have their physical form completed and signed by their physician and returned to the school nurse by March 1st.

May I also remind you that if your child requires medications at any time during the school year, that you obtain a note from your physician giving the school nurse permission to administer that medication.

Thank you for your cooperation.

Sara Maria Rodrigues
School Nurse



Physicians Examination Form Page 1

Student's Name _____
Last First MI Phone

Address _____
City State Zip

Date of Birth _____ Sex _____ Grade level in Sept _____

Mother's Name _____ Father's Name _____
 Address _____ Address _____
 Phone _____ Phone _____

Student's Medical History (to be completed by parent or physician)

	Yes	No	Date	Description/Reason
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Blood Disorders.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cancer.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chicken Pox.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Headaches.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hearing Problem/Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney/Urinary Tract Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Medication Reactions	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Orthopedic Disorder.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Scoliosis.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Strep Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ulcer/Gastrointestinal Disorder.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Visual Problem				
/Glasses/Contact Lenses.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Is the student now under the care of a physician? Yes No

Does the student take any regular medication? Yes No Please name medication and dosage below.

Has the student ever been advised by a physician not to play a sport? Yes No

Are there any other physical or emotional conditions that might bear on this child's abilities or performance?

Comments: _____



Physicians Examination Form Page 2

Height _____ Weight _____ Blood Pressure _____ Pulse _____
 Vision Without Correction: R 20/ _____ L 20/ _____ Both 20/ _____
 Vision With Correction: R 20/ _____ L 20/ _____ Both 20/ _____
 Hearing: Right _____ Left _____
 Nutrition (please note significant weight gain or loss in the past year) _____

Head & Neck _____ Lungs _____ Extremities _____
 Nose _____ Heart _____ Neurological _____
 Eyes _____ Abdomen _____ Urinalysis _____
 Ears _____ Back _____ Hemoglobin/Hematocrit _____
 Throat _____ Genitalia _____ Scoliosis Screening _____
 Chest/Breast _____ Hernia _____ If positive, treatment? _____
 Comments: _____

TO BE COMPLETED BY PHYSICIAN

A. New Students—Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.

Returning Students—Please note date of last booster or any other immunization that has been given in the last year.

VACCINE TYPE	DISEASE MO/DAY/YR	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTP) (If Td, DtaP or DT indicate in corner box)							
POLIO- ORAL POLIO VACCINE (OPV) (If Salk vaccine indicate IPV in corner box)							
MEASELS, MUMPS RUBELLA (MMR)							
MEASELS					Measels Serology	Date:	Titer:
RUBELLA					Rubella Serology	Date:	Titer:
MUMPS					Mumps Serology	Date:	Titer:
HAEMOPHILUS B (HIB)							
HEPATITIS B							
OTHER (SPECIFY)							

Provisional Admission Attached—Date Granted _____ Medical Exemption Attached Religious Exemption Attached

B. Mantoux Tuberculin Test Date _____ **Result** _____ **If positive, did student have chest X-Ray?** _____ **Result** _____

Based on this history/physical, this student:

- may participate in competitive athletics and physical education activities.
- has health problems, which prohibit participation in the following athletic activities.

Physician's Name _____

Address _____

Physician's Signature _____

Date of Examination _____

Telephone _____