

Physical Exam Record

To be completed by certified healthcare professional

Student's Name				Date of Birth / /	Age	Sex (M/F)	Grade	
Does the child have a diagnosed medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify:</i>								
Does the child have a health condition that may require EMERGENCY ACTION while at school? <input type="checkbox"/> No <input type="checkbox"/> Yes (e.g.: seizure, severe allergic reaction, diabetes) <i>Specify:</i>								
Is the child on prescription medication? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify medication and diagnosis:</i>								
Are any immunization, booster, or revaccinations indicated? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify type and due date:</i>								
Does the child have history of chicken pox disease? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify date:</i>								
Does the child require any restriction of physical activity in school? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>Specify nature and duration of restriction:</i>								
EXAM FINDINGS/CONCERNS								
Physical Exam	WNL	ABNL	Area of Concern	Health Area Of Concern	Yes	No	Referred for Evaluation	
Head				Developmental				
Eyes				Mobility				
ENT				Speech/language				
Neuro				Hearing				
Dental				History of frequent ear infections				
Respiratory				Vision				
Cardiac				Nutrition				
GI/GU				History of traumatic head injury				
Abdomen				Signs of acanthosis nigricans				
Endocrine				Learning disability				
Skin				Attention deficit hyperactivity disorder (ADHD)				
Genital				Psychosocial				
Orthopedic				Other:				
<i>Please explain any abnormal or area of concern findings:</i>								
SCREENING RESULTS								
Height:	ft.	in.	Weight:	lbs.	Body Mass Index (BMI):			
Blood Pressure:				Vision: L 20/		R 20/	Both 20/	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/>
Print Name				Signature of Healthcare Provider			Date / /	