



## Physical Exam Record

To be completed by certified healthcare professional

| <b>Student's Name</b>  |     |      |                 | Date of Birth<br>/ /                            | Age                    | Sex (M/F) | Grade                   |  |
|--|-----|------|-----------------|---|------------------------|-----------|-------------------------|--|
| Does the child have a diagnosed medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes<br><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<br>(e.g.: seizure, severe allergic reaction, diabetes)<br><i>Specify:</i> |     |      |                 |   |                        |           |                         |  |
| Is the child on prescription medication? <input type="checkbox"/> No <input type="checkbox"/> Yes<br><i>Specify medication and diagnosis:</i>  |     |      |                 |   |                        |           |                         |  |
| Are any immunization, booster, or revaccinations indicated? <input type="checkbox"/> No <input type="checkbox"/> Yes<br><i>Specify type and due date:</i>  |     |      |                 |   |                        |           |                         |  |
| Does the child have history of chicken pox disease? <input type="checkbox"/> No <input type="checkbox"/> Yes<br><i>Specify date:</i>   |     |      |                 |   |                        |           |                         |  |
| Does the child require any restriction of physical activity in school? <input type="checkbox"/> No <input type="checkbox"/> Yes<br><i>Specify nature and duration of restriction:</i>  |     |      |                 |   |                        |           |                         |  |
| <b>EXAM FINDINGS/CONCERNS</b>  |     |      |                 |   |                        |           |                         |  |
| 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>  |     |      |                 |   |                        |           |                         |  |
| <b>SCREENING RESULTS</b>   |     |      |                 |   |                        |           |                         |  |
| 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"/> |
| <b>Print Name</b>  |     |      |                 | <b>Signature of Healthcare Provider</b>         |                        |           | <b>Date</b><br>/ /      |  |