



SCHOOL DISTRICT 197

West St. Paul + Mendota Heights + Eagan Area

INDEPENDENT SCHOOL DISTRICT NO. 197

PHYSICAL EXAM FORM

STUDENT _____ **DATE OF BIRTH** _____

EXAMINATION		TESTS	MEASUREMENTS		
Indicate Normal (N) or Abnormal (AB) If Abnormal include comments		Indicate Normal (N) or Abnormal (AB) If Abnormal include comments	Give exact value		
Skin/lymph _____	Lungs _____	Hemoglobin _____	Blood Pressure _____		
Eyes _____	Abdomen _____	Urine _____	Height _____		
Ears _____	Genital/Urinary _____	Other _____	Weight _____		
Nose _____	Orthopedic/feet _____	(Specify)	Vision	R 20/	L20/
Mouth _____	Neurological _____		Eyeglasses	Yes	No
Throat _____	Speech _____		Hearing	R _____	L _____
Neck _____	Other (Specify) _____		With Hearing aid	Yes	No

HEALTH CLASSIFICATION FOR SCHOOL PROGRAM

_____ Is in excellent health and able to participate in the entire school program.

_____ There is a condition which may limit participation (Circle any that apply)

Classroom Activities _____ Physical Education _____

Ongoing Therapies and Medications: (Specify type and dose) _____

Allergies: _____

COMMENTS _____

SIGNATURE and TITLE of EXAMINER _____ Date _____

Examiner Phone _____

IMMUNIZATION RECORD

Please use form on back to document all immunizations