



## ANNUAL PHYSICAL EXAMINATION

Student's Name: \_\_\_\_\_ Gender \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height: \_\_\_\_\_ VISION **Required for Grades 7 and 9**  
Weight: \_\_\_\_\_ Uncorrected Corrected  
Pulse: \_\_\_\_\_ Right \_\_\_\_\_  
Blood Pressure: \_\_\_\_\_ Left \_\_\_\_\_

HEARING **Required for Grade 7**  
*Hearing screenings are not performed at Hebron Academy*  
Pass \_\_\_\_\_ Refer \_\_\_\_\_

Are the following systems normal?	YES	NO	Findings
Skin			
Head, Eyes			
Ears, Nose, Throat			
Thyroid, Lymph Nodes			
Chest, Lungs			
Breasts			
Heart			
Abdomen			
Genitourinary (PMS)			
Extremities, Back/Scoliosis			
Metabolic, Endocrine			
Neurological			
Psychological (depression, anxiety)			

Medications (dose, time taken, indication) \_\_\_\_\_  
 Allergies (drug/food/environmental): \_\_\_\_\_  
 Anaphylaxis Reaction to: \_\_\_\_\_ **Epipen**-carry at all times and instructed in self-administration? Yes  No   
 Are there any dietary restrictions? \_\_\_\_\_  
 Any history of weight issues or an eating disorder? \_\_\_\_\_  
 Swimming Ability: non-swimmer \_\_\_\_\_ weak swimmer \_\_\_\_\_ moderate swimmer \_\_\_\_\_  
 Are there any sports restrictions? \_\_\_\_\_  
 Any history of concussions? \_\_\_\_\_  
 Do you recommend counseling? \_\_\_\_\_  
 Any significant medical problems not noted above? \_\_\_\_\_

A Tuberculin Skin test (PPD) obtained annually is **REQUIRED** for students who live in Asia (except Japan), Africa, the Middle East, Eastern Europe, Russia, Central and South America including Mexico and the Caribbean. Other students are not required to have a PPD test unless their physician determines they are at risk.

TB Risk: HIGH  LOW  If high, date of PPD: \_\_\_\_/\_\_\_\_/\_\_\_\_ Test Result: POSITIVE  NEGATIVE

If PPD was positive, a chest X-Ray is required after the date of last PPD. Chest X-Ray results: \_\_\_\_\_

If PPD was positive, did the student receive treatment with INH or other? YES  NO

If yes, please describe treatment: \_\_\_\_\_

Has the student received a BCG? YES  NO  BCG received on: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_