

WISSAHICKON SCHOOL DISTRICT PHYSICAL EXAMINATION FORM

SECTION 1 – TO BE COMPLETED BY PARENT(S)			
Child's Name (Last) _____ (First) _____	DOB / /	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Grade
Parent/Guardian Name _____	Primary Telephone Number _____	Work Telephone Number _____	
Parent/Guardian Name _____	Primary Telephone Number _____	Work Telephone Number _____	
Parental Concerns for Physician Review:			
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>			
Parent/Guardian Signature _____			Date _____
SECTION 2 – TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination _____		Results of physical examination normal? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Abnormalities Noted		Height _____	
		Weight _____	
		Blood Pressure _____	
		Pulse _____	
IMMUNIZATIONS		<input type="checkbox"/> Immunization Record Attached	
MEDICAL CONDITIONS			
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Medications/Treatments • List medications/treatments	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Limitations to Physical Activity • List limitations/special considerations	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Allergies • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Special Diet • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
Emergency Plans • List emergency plan that may be needed and signs/symptoms to watch for	<input type="checkbox"/> None <input type="checkbox"/> Care Plan Attached	Comments:	
PREVENTATIVE HEALTH SCREENINGS			
Hearing	Pass: <input type="checkbox"/>	Comment if abnormal:	
Vision	Pass: <input type="checkbox"/>	Comment if abnormal:	
Scoliosis	Pass: <input type="checkbox"/> N/A: <input type="checkbox"/>	Comment if abnormal:	
TB (mm of induration)	Pass: <input type="checkbox"/> N/A: <input type="checkbox"/>	Date results read:	Results:
<input type="checkbox"/> <i>I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education, unless noted above.</i>			
Name of Health Care Provider (Print) _____			Signature/Date _____