'IOLANI SCHOOL
YEARLY PHYSICAL EXAMINATION FORM

STUDENT NAME [ ] **DATE OF BIRTH** [ ] **MALE** ☐ **FEMALE** ☐

***EXAM PERFORMED ON:* ________________ Height______ Weight______ B/P _____ /_____ Pulse ______**

	Normal	Describe Abnormal		Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
Heart			Arms/Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/Ankles		
Past medical hx of:					

Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD,DO,PA or APRN)

Vision Screening

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐Referral made

Auditory Screening

Type:	Right	Left
	Pass	*Pass*
	Fail	*Fail*

☐Referral made

Postural

☐ No spinal abnormality

☐ Spinal abnormality:

Mild *Moderate* *Marked*

☐Referral made

Health Conditions:

Allergies ☐None ☐Yes*(circle one): *Life Threatening* *Non-Life Threatening* *Seasonal* *Contact*

Asthma ☐No ☐Yes*(circle one): *Intermittent* *Mild* *Moderate* *Severe* *Exercise Induced* *Cold Induced*

Diabetes ☐No ☐Yes*(circle one): *Type I* *Type II*

Seizures ☐No ☐Yes*(circle one): *Epileptic* *Rolandic* *Other__________*

**Action plan REQUIRED for all yes answers*

Physical Activity:

This student: ☐**MAY participate fully in school program/PE/athletics and competitive sports**

☐**MAY NOT** participate in school program/PE/athletics and competitive sports

☐Has **RESTRICTIONS** and a detailed note has been attached or previously submitted to the 'Iolani School Infirmary

Medications:

Daily: ____ PRN: _____________________________________

>Please complete Medication Administration Form for all medications to be administered by school nurse during the school day

IMMUNIZATIONS: ☐Up to date ☐New student ***(must attach Immunization Record)*** ☐Tetanus updated and charted below

DTP. DTaP, DT or Td,Tdap		Other		Other	
Type	Date	Type	Date	Type	Date

Tuberculosis Screening REQUIRED for ALL *new students* and ALL *grade 7* (unless entered 'Iolani School in grade 6)

☐State of Hawaii TB Risk Assessment for Adults and Children (TB document F&G) completed and attached**

☐Tuberculin skin test or Chest X-ray completed and charted below

**REQUIRED FOR ALL STUDENTS THAT HAVE TRAVELED OUTSIDE THE U.S. FOR A DURATION OF 4 WEEKS OR MORE

Intradermal	Date given	Date Read	Results (mm)	Practitioner
Chest x-ray	Date	Results	Location	Practitioner

PHYSICIAN: I hereby certify that I have examined this student and reviewed the immunization record.

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Signature of U.S. Licensed Practitioner (MD,DO,PA or APRN) **Date Signed** **Printed/Stamped Name and Phone Number**