

# Malvern Preparatory School

## Physical Examination Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

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*Immunization History*

\*\*\*Please attach a copy of the student's immunization record.

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*Health History*

Allergies: \_\_\_\_\_ Surgeries: \_\_\_\_\_

Serious Illnesses: \_\_\_\_\_

Please list any other significant medical information including medication(s): \_\_\_\_\_  
 \_\_\_\_\_

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*Physical Examination*

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Vision: Far Right 20/\_\_\_\_ Left 20/\_\_\_\_ Near Right 20/\_\_\_\_ Left 20/\_\_\_\_ Wears Corrective Lenses: Yes No

	N	AB		N	AB		N	AB
General Nutrition			Lymph Glands			Skeleton		
Skin			Heart			Posture		
Eyes			Lungs			Emotional Status		
Nose & Throat			Abdomen			Hearing		
Teeth & Gingiva			Genitalia			Scoliosis: State Mandate for		
Ears			Neuromuscular System			Grade 6 and Grade 7		

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Is the student under treatment? Yes \_\_No \_\_ Does the student have restrictions for athletics or physical education? Yes \_\_No \_\_

Please explain the above listed abnormal findings and/or restrictions and include the recommended treatment: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_