Physical Examination Form-Grades 1,3,and 6 thru 12

***To be completed by a licensed health care provider.**

Date of exam(must be within the past 12 months)_____

Student's Name_____ DOB_____ Grade in September_____

Sex assigned at birth_____ Weight_____Height_____Pulse_____BP_____

1- Please attach Immunization Record including Covid vaccine record.

2-Allergies(food,medication,environmental)_____

Describe reaction:_____

Is this student prescribed an Epi-pen, Auvi-Q and/or inhaler? _____

3- Entire physical examination within normal limits: _____Yes _____No

If no please list significant findings:_____

4-Significant Past Medical History:
_____

5-Current Medications:
_____

6-Scoliosis screening: _____Pass _____Fail Follow-up_____

7-Vision Test: _____Pass _____Fail Follow-up_____

8-Hearing Test: _____Pass _____Fail Follow-up_____

*** The above named student is cleared for all sports and physical activities, both intramural and inter-scholastic, during the school year_____. (REQUIRED)**

Print name of examining health care provider _____

Address/phone_____

Signature of examining health care provider_____