DOANE academy est. 1837

2022 - 2023 Student
Physical Evaluation Form
for Primary through 5th grades

Student's Name: _____

2022 - 2023 Grade level: _____ Date of Birth: _____

TO BE COMPLETED BY PHYSICIAN:

(A) Drug Allergies: _____Reaction:_____

Food Allergies: _____Reaction:_____

Other allergies: _____Reaction:_____

Does the student require an EPIPEN? Yes_____ No_____

*******All students diagnosed with severe allergies must have an allergy action plan completed**

(B) List any history of serious/chronic illness (INCLUDING ASTHMA), injury, surgeries or mental health issues.

_____

_____

_____

Does the student have an inhaler? YES _____ NO _____

May the student self carry the inhaler? YES _____ NO _____

*******All students diagnosed with asthma must have an asthma action plan completed**

Student's Name: _____

(C) Physical Exam **(must be completed in full)** :

Height: _____ Weight: _____lbs BP: _____ Heart Rate: _____

Scoliosis: _____(Y/N) If present - Intervention: _____

***Hearing: R _____ L _____ (pass/fail) Referral: _____ (Y/N)

***Vision: R_____ L_____ OU_____ Glasses/Contacts: _____ (Y/N) Referral: ___(Y/N)

General appearance _____ Head/Neck _____ Eyes _____ Nose/Mouth _____
Teeth _____ Heart _____ Lungs _____ Skin _____ Abdomen _____
Musculoskeletal _____ Neurologic _____ GU _____ Other _____

Comments/Abnormal findings:_____
_____

(D) Current Medications: Reason for taking medication:

_____ _____
_____ _____
_____ _____

(E) Clearances:

_____ Student is cleared for **ALL** sports/gym without restrictions.

_____ Student is **NOT** cleared for sports until evaluation/ treatment of:
_____

_____ Student is cleared for **LIMITED** participation.
Limits: _____
Due to: _____

(F) Student may have the following over the counter drugs with parental consent:
Acetaminophen, Ibuprofen, Naproxen Sodium, Calcium Carbonate (Tums),
NaphconA (allergy relief eye drops), & throat/cough drops.
{Dosage age/weight appropriate}

Provider's Initials: _____

Student's name:_____

***** **PLEASE attach immunization record to this completed form.** *****

History reviewed and student examined by:

_____ _____

(Physician's / Provider's Signature) (Date of Exam)

_____ _____

(Print Physician's / Provider's Name) (Today's date if different than exam date)

Physician's / Provider's Stamp or Address and Phone #