



Student Health Forms

Suffield Academy Health Center 185 North Main Street Suffield, Connecticut 06078
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Student Information

FIRST NAME

LAST NAME

DOB

PHYSICAL EXAMINATION RECORD

Exam date _____ Allergies _____

All students must have a physical exam that is current (within 12 months) at all times to participate in school programs and activities.

Blood pressure _____ Pulse _____

Height [inches] _____ Weight [pound] _____

Urinalysis _____

sugar _____

albumin _____

micro _____

Hemoglobin or hematocrit _____

Prior medical/psychological conditions _____

Previous musculoskeletal injuries _____

Current medical/psychological conditions _____

Psychotherapy or counseling history _____

Asthma [If yes, please provide a copy of Asthma Action Plan]

No Yes Intermittent Mild Persistent Moderate Persistent

Severe Persistent Exercise Induced

Anaphalaxis [If yes to food, please provide a copy of Food Allergy Action Plan]

No Yes Food Insects Latex Unknown Source

History of Anaphalaxis No Yes Epipen Required No Yes

REVIEW OF SYSTEMS Describe fully. Use additional sheet if needed.

	WNL	ABNL
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other conditions		

Please list dose and schedule for each medication

For returning students only: please list immunizations since last physical.

My examination finds the student named above to be in good health, free from contagion, and physically and emotionally qualified for a full program of study and sports.

Yes No If no, please explain _____

Print or type name and address of examining physician _____

Physician's Signature [required]