STUDENT PHYSICAL FORM

For Students New to the District Under Age 9

PHYSICAL EXAMINATION must be completed by health care provider approved to perform health assessments.

Student's Name _____

Date of Birth _____ Male/Female _____

Address _____

City _____ State _____ ZIP _____

Parent/Guardian Name _____

Phone (Cell) _____ Home _____

Code Each Item as Follows: 0= No significant findings 1=Significant findings	Code	Description of Findings	Labs/Vital Signs and Screening Results
General Appearance Integument Head/Neck Oral/Dental Thorax Breasts Cardiovascular Abdomen Musculoskeletal Genitourinary Neurological			Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____ Vision:_____ Hearing:_____ Labs: Hgb:_____ UA:_____

Significant Assessment Findings (to include asthma/allergies):

Recommendations: (Include referrals)

Follow-Up:

Additional information may be attached

_____ _____

Signature of Licensed Physician or Nurse approved to perform Health Assessments Date

Statement of Consent: In order to better serve the health needs of my child, I hereby give my permission for the transfer of health screening records to school and other appropriate health professionals.

Parent's Signature _____ Date_____