Albuquerque Public Schools
Nursing Services

School_____
Address_____

Physical Examination

(*to be completed by a physician/provider*)

Note to physician/provider: New Mexico Standards for Special Education require that certain special education students receive current recommendations and a physical exam from their provider, inclusive of medical diagnoses (and ICD-9 codes) and etiology for all physical and/or health impairments, prognosis, physical limitations, cognitive limitations, emotional/social limitations, medications, and assistive or prosthetic devices. We thank you for your cooperation in completing all pages of this form in full.

Name of child/student	Student #

Diagnoses/Past Procedures

Primary Medical Diagnoses/Problem List

1._____ICD-9 code_____
2._____ICD-9 code_____
3._____ICD-9 code_____
4._____ICD-9 code_____
5._____ICD-9 code_____

Synopsis statement (baseline status, etiologies, prognosis)_____
_____
_____

Medications:

_____
_____
_____
_____
_____

Prostheses/Appliances/AdvancedTechnology Devices:

_____
_____
_____
_____
_____

Will medication or any procedures (e.g. catheterizations, suctioning, oxygen, tube feeding, emergency care, etc.) be done routinely or on an as needed or emergency basis? yes no **Explain:**_____
_____*(If yes, please fill out the appropriate APS authorization/order forms)*

Immunizations: indicate month/day/year of immunizations

DPT							**HEP B**					
DT							**HEP A**					
IPV							**Varicella**					
MMR							**TB status**					
HIB							**Other**					

Immunization Medical Exemption required? yes no Reason:_____

Antibiotic prophylaxis: yes no Indication:_____Medication and dose:_____

Height:_____Weight:_____BMI:_____BMI%ile:_____FOC:_____BP:____/___

Allergies: Medications/Foods to be avoided

_____
_____
_____

and why:

_____
_____
_____

Procedures to be avoided

_____

and why:

_____

Continued on reverse

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Objective Findings on Exam

General Inspection:_____

Skin/Nails/Hair:_____

Head/Face:_____

Eyes:_____**Visual Acuity R (20/_____) L (20/_____) Glasses? Yes No**

Ears:_____**PE Tubes R ( ) L ( ) Hearing Aids R ( ) L ( )**

Nose/Sinuses:_____

Mouth/Throat:_____

Neck:_____

Chest/Thorax:_____

Lungs:_____**Heart:**_____

PVS:_____

Musculoskeletal:_____

Abdomen/GI:_____**Hernia? Yes No**

Genitourinary:_____

Neurologic:_____**VP Shunt R ( ) L ( )**

_____**Seizure Disorder? Yes No**

If this child has a seizure disorder, please describe the following: Type of seizure(s) and severity?_____
_____**Prodromal symptoms?**_____
How well are seizures controlled?_____

Are there any abnormalities in physical, mental/cognitive, emotional/social, motor or speech development? Circle those that apply and explain_____
_____
_____

Would you approve an evaluation and/or therapy by physical therapy, occupational therapy, speech pathology, nursing services, nutrition services, assistive technology, if indicated? Yes No Comments:_____
_____
_____

Can this child participate in an adapted physical education program, including closely supervised **swimming** instruction? Yes No Can this child participate in Special Olympics? Yes No Comments/restrictions:
_____
_____

If this child has Down Syndrome, has he or she been evaluated for atlantoaxial dislocation? Yes No If yes, give date of x-ray evaluation:_____Results: Positive ( ) Negative ( )
Are there any observations of this child which you would like reported to you? Yes No Explain:_____
_____

Date:_____Signature of Provider:_____Phone:_____
Name of Provider (printed):_____Address:_____