Thompson School District Non-Sports Physical Form

Recommended for all students entering grades K, 4th ,7th ,10th grade. Please complete and return to the school's health office.

Student_______________________________ Date of Birth_______________________

Parent/Guardian____

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis						
DT	Diphtheria, Tetanus (ped)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus infl*. type b						
IPV/OPV	Polio						
PCV	Pneumococcal conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox						

Vaccines recorded below this line are recommended. Recording of dates is encouraged.

HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

PHYSICAL EXAMINATION

Height:________________ Weight:________________ Blood Pressure: ________/___________

	Normal	Abnormal	Comments
Scalp/Skin:	_______	_________	____________________
Heart:	_______	_________	____________________
Lungs:	_______	_________	____________________
ENT:	_______	_________	____________________
Abdomen:	_______	_________	____________________
Musculo-skeletal	_______	_________	____________________
Neurological	______	_________	____________________

Other/Additional comments:____

Vision Screening: Corrective lenses? Yes or No?

Distance: Rt 20/_________ Lt 20/___________ Both 20/___________ Pass or Refer to eye doctor or unable to test/rescreen? (circle one)

Hearing Screening:	Pass	Fail	Refer to Audiologist
Right ear:	________	_________	____________________
Left ear:	________	__________	_____________________

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
ADHD			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgical history		
Dental problems			Vision problems		

List all prescription, over-the-counter, herbal medications the child takes regularly:

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Physician's name (printed):_________________________ Physician's signature: ____________________________

Date: ______________________

Parent/Guardian Permit Signature:____ Date: __________________

Updated 8/2014 AB