Andover Regional School District Physical Examination Form

_____ ____ Male ____ Female

Last Name First

_____

Date of Birth Blood Pressure Weight Height

Examination: Do you find any evidence of abnormality of the following:

General Appearance	Yes____ No____	Blood Pressure	Yes ____ No____
Skin	Yes____ No____	Lungs	Yes ____ No____
Allergies	Yes____ No____	Abdomen	Yes____ No____
Eyes	Yes____ No____	Orthopedic	Yes____ No____
Ears/Hearing	Yes____ No____	Skeletal/Posture	Yes____ No____
Nose/Throat	Yes____ No____	Scoliosis	Yes____ No____
Glands/Thyroid	Yes____ No____	Neuromuscular	Yes____ No____
Teeth/Gingival Disease	Yes____ No____	Genito-Urinary	Yes____ No____
Heart	Yes____ No____	Emotional Status	Yes____ No____
Nutrition	Yes____ No____	Speech	Yes____ No____
Feet	Yes____ No____	Hernia	Yes____ No____

If yes to any of the above, please elaborate: _____

_____

_____

Medical History: Serious illness, operations, accidents, handicapping conditions - (congenital or acquired):

_____

_____

Immunizations. **Please attach immunization history.**

Life threatening allergies? (Epi-Pen required?): _____

Does child have asthma? ___Yes ___No If yes, please list medications. _____
Is this child under treatment? ___Yes ___No. If yes, please explain. _____
Should this child have any restrictions on play or physical education activities? ___Yes ___No If yes, please explain: _____

Other recommendations of information that may be helpful in the emotional, social or physical development of this child: _____

_____

_____ _____ _____ _____

Physician Name Physician Signature Physician Stamp Date of Exam