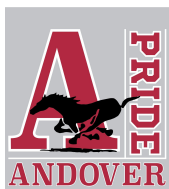


Andover Regional School District Physical Examination Form



____ 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