THS Physical Assessment Form
2024-2025

Name______________________ Date of Birth______ Grade ___

PHYSICIAN CLEARANCE IS REQUIRED FOR PARTICIPATION IN ALL ACTIVITIES AND SPORTS AT ALL GRADE LEVELS ANNUALLY

☐ **Cleared for full participation**
☐ **Cleared with restrictions:** ________________________________
☐ **May not participate (reason):** ________________________________

Physician Signature: Date:	Office Stamp

To be completed by the Physician:

Date of Exam: ________________

Height:	________ inches	Scoliosis Screening:	☐ Pass	☐ Fail
Weight:	________ lbs.	Hearing Test:	☐ Pass	☐ Fail
BP:	____/_____	Vision Test:	☐ Pass	☐ Fail

Allergies: ____

☐ Epinephrine is prescribed for anaphylactic reaction and must be available at school*.

History of anaphylaxis: ☐ Yes ☐ No   History of Asthma: ☐ Yes ☐ No

Medications taken on a regular basis: ________________________________

Medications required at school*: ________________________________

*Please complete the form "**Physician Order for Prescription Medication in School**"

Current Health Problems: (please check all that apply)

☐ ADHD-Inattentive	☐ Depression	☐ Musculoskeletal problem
ADHD-Hyperactive	☐ Developmental delay	☐ Neurological problem
☐ Anxiety	☐ Diabetes	☐ Respiratory problem
☐ Asthma	☐ Gastrointestinal problem	☐ Seizures or convulsions
☐ Athletic injury	☐ Hearing problem	☐ Skin problem
☐ Bleeding disorder	☐ Headaches	☐ Speech problem
☐ Cardiac problem	☐ History of Fainting	☐ Surgical history
☐ Concussion Date ______	☐ Liver or Kidney problem	☐ Vision problem
	☐ Migraines	☐ Other

Additional details of health problems you have checked as needed ________________________________

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This student is current with all recommended immunizations. ☐ Yes ☐ No

Please upload current record to your Magnus account in the IMMUNIZATION RECORD section.