School City of Hobart

Elementary Physical Exam

STUDENT NAME LAST FIRST M.I	BIRTH DATE	GENDER	GRADE

HEALTH HISTORY: Parent or Guardian answer questions and sign below. Please explain all **YES** answers.

STUDENT HISTORY	YES	NO	EXPLAIN	STUDENT HISTORY	YES	NO	EXPLAIN
Asthma				Seizures or Epilepsy			
Blood Disorder				Skin problem			
Cardiac Problems				Urinary Problem			
Diabetes				Behavior Problem			
Ear/ Hearing Problem				Hospitalizations			
Eye/ Vision Problem				Surgery			
Gastrointestinal Problem				Serious Injury or Illness			
Bone or Joint Problem				Other Problems			

ALLERGIES (FOOD, DRUGS, INSECTS OR OTHER)

TYPE:	REACTION:

MEDICATION (List all prescribed, emergency, or over-the-counter)

NAME	DOSE	REASON

PHYSICAL EXAM – Health care provider complete and sign below

Height Weight B/P / Pulse

SYSTEMS REVIEW	NORMAL	ABNORMAL	COMMENTS
General Appearance			
Skin			
Eyes			
Ear, Nose, Mouth and Throat			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurologic			
Endocrine			
Psychiatric			
Hematologic			

I approve this student's participation in recess and physical education (Circle what applies) YES NO MODIFIED

Explain modifications if needed:

Health care Provider (MD, DO, APN, FNP, PA) must sign

Signature **Date**

Address **Phone**

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.