North Scott Community School District

Report of Physical Examination

NAME	BIRTH DATE	GENDER
ADDRESS		
PARENT/GUARDIAN NAME	PHONE	

TO BE COMPLETED BY PHYSICIAN

Height	Weight	BP	Hearing	Vision	Lead
				R L Both	

HEALTH HISTORY

Diseases/Chronic Illnesses	Allergies	Need Modifications
Asthma	Hay Fever	Dietary
Chicken Pox	Insect Stings	Special Equipment
Heart Disease	Food	Other
Whooping Cough	Medications	
Seizures	Other	
Diabetes		
Hospitalizations:		
Operations / Serious Illnesses:		
Medications:		

PHYSICAL EXAMINATION

	Normal	Comments		Normal	Comments
Skin			Genitourinary		
Ears			Gastrointestinal		
Eyes			Neurological		
Nose/Throat			Musculoskeletal		
Glands			Spinal Exam		
Mouth/Dental			Nutritional		
Cardiovascular			Mental Health		
Respiratory			General Comments		

Physician Signature

Date