

2025 - 2026 Student  
Physical Evaluation Form  
for Primary through 5th grades

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Student's Name: \_\_\_\_\_

2025 - 2026 Grade level: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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**TO BE COMPLETED BY PHYSICIAN:**

(A) **Drug Allergies:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_

**Food Allergies:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_

**Other allergies:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_

Does the student require EPINEPHREN? Yes \_\_\_\_\_ **\*\*\*need action plan** No \_\_\_\_\_

**\*\*\*\*\*All students diagnosed with severe allergies must have an  
allergy action plan completed & submitted**

(B) List any history of serious/chronic illness (INCLUDING ASTHMA), injury, surgeries or  
mental health issues.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the student have an inhaler? YES \_\_\_\_\_ **\*\*\*need action plan** NO \_\_\_\_\_

May the student self carry the inhaler? YES \_\_\_\_\_ NO \_\_\_\_\_

**\*\*\*\*\*All students diagnosed with asthma must have an  
asthma action plan completed & submitted**

Student's Name: \_\_\_\_\_

(C) Physical Exam **(must be completed in full)** :

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs BP: \_\_\_\_\_ Heart Rate: \_\_\_\_\_

Scoliosis: \_\_\_\_\_ (Y/N) **If present - Intervention:** \_\_\_\_\_

**\*\*\***Hearing: R \_\_\_\_\_ L \_\_\_\_\_ (pass/fail) Referral: \_\_\_\_\_ (Y/N)

**\*\*\***Vision: R \_\_\_\_\_ L \_\_\_\_\_ OU \_\_\_\_\_ Glasses/Contacts: \_\_\_\_\_ (Y/N) Referral: \_\_\_\_\_ (Y/N)

General appearance \_\_\_\_\_ Head/Neck \_\_\_\_\_ Eyes \_\_\_\_\_ Nose/Mouth \_\_\_\_\_  
Teeth \_\_\_\_\_ Heart \_\_\_\_\_ Lungs \_\_\_\_\_ Skin \_\_\_\_\_ Abdomen \_\_\_\_\_  
Musculoskeletal \_\_\_\_\_ Neurologic \_\_\_\_\_ GU \_\_\_\_\_ Other \_\_\_\_\_

Comments/Abnormal findings: \_\_\_\_\_  
\_\_\_\_\_

(D) Current Medications:

Reason for taking medication:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(E) Clearances:

\_\_\_\_\_ Student is cleared for **ALL** sports/gym without restrictions.

\_\_\_\_\_ Student is **NOT** cleared for sports until evaluation/ treatment of:  
\_\_\_\_\_

\_\_\_\_\_ Student is cleared for **LIMITED** participation.

Limits: \_\_\_\_\_

Due to: \_\_\_\_\_

(F) Student may have the following over the counter drugs with parental consent:

Acetaminophen, Ibuprofen, Naproxen Sodium, Calcium Carbonate (Tums),

NaphconA (allergy relief eye drops), & throat/cough drops.

{Dosage age/weight appropriate}

**Provider's Initials:** \_\_\_\_\_

Student's name: \_\_\_\_\_

**\*\*\*\*\* PLEASE attach immunization record to \*\*\*\*\***  
**this completed form.**

History reviewed and student examined by:

\_\_\_\_\_  
(Physician's / Provider's Signature)

\_\_\_\_\_  
(Date of Exam)

\_\_\_\_\_  
(Print Physician's / Provider's Name)

\_\_\_\_\_  
(Today's date if different than exam date)

Physician's / Provider's Stamp or Address and Phone #