



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form **before**
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)

Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

| GENERAL HEALTH: <i>Has the student...</i> | YES | NO |
|---|-----|----|
| 1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____ | | |
| 2. Ever stayed more than one night in the hospital? | | |
| 3. Ever had surgery? | | |
| 4. Ever had a seizure? | | |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ? | | |
| 6. Ever become ill while exercising in the heat? | | |
| 7. Had frequent muscle cramps when exercising? | | |
| HEAD/NECK/SPINE: <i>Has the student...</i> | YES | NO |
| 8. Had headaches with exercise? | | |
| 9. Ever had a head injury or concussion? | | |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling? | | |
| 12. Ever been unable to move arms or legs after being hit or falling? | | |
| 13. Noticed or been told he/she has a curved spine or scoliosis? | | |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury? | | |
| 15. Been prescribed glasses or contact lenses? | | |
| HEART/LUNGS: <i>Has the student...</i> | YES | NO |
| 16. Ever used an inhaler or taken asthma medicine? | | |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____ | | |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)? | | |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise? | | |
| 20. Had discomfort, pain, tightness or chest pressure during exercise? | | |
| 21. Felt his/her heart race or skip beats during exercise? | | |
| BONE/JOINT: <i>Has the student...</i> | YES | NO |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint? | | |
| 23. Had an injury to a muscle, ligament, or tendon? | | |
| 24. Had an injury that required a brace, cast, crutches, or orthotics? | | |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury? | | |
| 26. Had joints that become painful, swollen, feel warm, or look red? | | |
| SKIN: <i>Has the student...</i> | YES | NO |
| 27. Had any rashes, pressure sores, or other skin problems? | | |
| 28. Ever had herpes or a MRSA skin infection? | | |

| GENITOURINARY: <i>Has the student...</i> | YES | NO |
|--|-----|----|
| 29. Had groin pain or a painful bulge or hernia in the groin area? | | |
| 30. Had a history of urinary tract infections or bedwetting? | | |
| 31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____ | | |
| DENTAL: | YES | NO |
| 32. Has the student had any pain or problems with his/her gums or teeth? | | |
| 33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years | | |
| SOCIAL/LEARNING: <i>Has the student...</i> | YES | NO |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.? | | |
| 35. Been bullied or experienced bullying behavior? | | |
| 36. Experienced major grief, trauma, or other significant life event? | | |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends? | | |
| 38. Been worried, sad, upset, or angry much of the time? | | |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm? | | |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight? | | |
| 41. Used (or currently uses) tobacco, alcohol, or drugs? | | |
| FAMILY HEALTH: | YES | NO |
| 42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other: _____ | | |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____ | | |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning? | | |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)? | | |
| QUESTIONS OR CONCERNS | YES | NO |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.) | | |

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

| STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |
|--|-----------|-----------|-------|--|
| Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/> | CHECK ONE | | | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
| | NORMAL | *ABNORMAL | DEFER | |
| Height: () inches | | | | |
| Weight: () pounds | | | | |
| BMI: () | | | | |
| BMI-for-Age Percentile: () % | | | | |
| Pulse: () | | | | |
| Blood Pressure: (/) | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes/Vision Corrected <input type="checkbox"/> | | | | |
| Ears/Hearing | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |
| Spine (Scoliosis) | | | | |
| Other | | | | |

| TUBERCULIN TEST | DATE APPLIED | DATE READ | RESULT/FOLLOW-UP |
|-----------------|--------------|-----------|------------------|
| | | | |
| | | | |

| MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION |
|---|
| (Additional space on page 4) |

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|---|
| Parent/guardian present during exam: Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Physical exam performed at: Personal Health Care Provider's Office <input type="checkbox"/> School <input type="checkbox"/> Date of exam _____ 20____ |
| Print name of examiner _____ |
| Print examiner's office address _____ Phone _____ |
| Signature of examiner _____ MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/> |