

**2026 - 2027 Student
Physical Evaluation Form
for Primary through 5th grades**

Student's Name: _____

2026 - 2027 Grade level: _____

Date of Birth: _____

TO BE COMPLETED BY PHYSICIAN:

(A) **Drug Allergies:** _____ **Reaction:** _____

Food Allergies: _____ **Reaction:** _____

Other allergies: _____ **Reaction:** _____

Does the student require EPINEPHRINE? 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: _____ in. 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),
Olopatadine HCl (allergy relief eye drops), Hydrocortisone cream & OTC 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 #