



Required for all new students and those entering kindergarten

TO BE COMPLETED BY PARENT

Student's Name: _____ Gender: _____ Date of Birth: _____ Entering Grade: _____ Key Y/N

Name of Parent/Guardian: _____

TO BE COMPLETED BY PHYSICIAN

Health Concerns: _____

Student's Allergies, type and response required: _____

Medications prescribed for the student: _____

PHYSICAL EXAM:

Height: _____ Weight: _____ B.P.: _____ Head: _____ Eyes: _____ Ears: _____
Throat: _____ Teeth: _____ Neck: _____ Chest: _____ Heart: _____
Lungs: _____ Abdomen: _____ G.U.: _____ Neurological: _____ Skin: _____
Ext: _____ Spine: _____ Restrictions: _____

*If seeking exemption for medical or religious reasons, you must provide a copy of doctor's certificate or religious exemption letter.

Vision screening information:

Passed vision screening: ☐ Yes ☐ No ☐ N/A

Concerns related to student's vision: _____

Hearing screening information:

Passed hearing screening: ☐ Yes ☐ No ☐ N/A

Concerns related to student's hearing: _____

ADDITIONAL COMMENTS:

Signature of Physician Printed Name Date

Address City State Zip Phone