

INDEPENDENT SCHOOL DISTRICT NO. 197

PHYSICAL EXAM FORM

STUDENT _____ DATE OF BIRTH _____

EXAMINATION	TESTS	MEASUREMENTS	
Indicate Normal (N) or Abnormal (AB) If Abnormal include comments	Indicate Normal (N) or Abnormal (AB) If Abnormal include comments	Give exact value	
Skin/lymph _____ Eyes _____ Ears _____ Nose _____ Mouth _____ Throat _____ Neck _____	Lungs _____ Abdomen _____ Genital/Urinary _____ Orthopedic/feet _____ Neurological _____ Speech _____ Other (Specify) _____	Hemoglobin _____ Urine _____ Other _____ (Specify)	Blood Pressure _____ Height _____ Weight _____ Vision R 20/ _____ L20/ _____ Eyeglasses Yes No Hearing R _____ L _____ With Hearing aid Yes No

HEALTH CLASSIFICATION FOR SCHOOL PROGRAM

_____ Is in excellent health and able to participate in the entire school program.

_____ There is a condition which may limit participation (Circle any that apply)

Classroom Activities _____ Physical Education _____

Ongoing Therapies and Medications: (Specify type and dose) _____

Allergies: _____

COMMENTS _____

SIGNATURE and TITLE of EXAMINER _____ Date _____

Examiner Phone _____

IMMUNIZATION RECORD

Please use form on back to document all immunizations