ROUTINE PHYSICAL EXAMINATION REPORT

STUDENT'S NAME: _____ **GRADE:** _____

DATE OF BIRTH: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES

This section <u>MUST</u> be complete in order for this form to be accepted!

Height: _____ Blood Pressure: _____ Hearing: R: _____ L: _____

Weight: _____ Pulse: _____ bpm Vision: R: 20/ _____ L: 20/ _____

Correction: Y / N Contacts: Y / N Eyeglasses: Y / N

Indicators	Normal? (circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/ Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/ Mouth/ Throat	YES	NO	
Heart: Murmurs/ Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (inc. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses	YES	NO	
Hernia? (if yes/possible, please explain)	NEG	YES/ possible	
Neck/Back/Spine: Range of Motion	YES	NO	
Scoliosis:	NEG.	YES/ possible	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological: Balance & Coordination:	YES	NO	
Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	

<u>MAKE A COPY FOR YOUR CHILD'S HOME HEALTH FILE</u>

**Continued on back of page

STUDENT'S NAME _____ **GRADE:**_____

PHYSICIAN OR PROVIDER MUST CONTINUE TO PROVIDE THE INFORMATION BELOW

Medications currently in use:
ATTACH COPY OF COMPLETE IMMUNIZATION RECORD.
Allergies: Yes / No LIST Allergies, if any:
Additional Comments:

General Diagnosis: _____

Recommendations: _____

_____

_____

EXAMINED BY: Health Care Provider _____
School Physician _____

I hereby certify that the above named student was examined by me and found physically fit to engage in all physical activity including physical education and recess.

Health Care Provider's Signature: _____

Circle ONE: MD DO NP PA

↑PLEASE STAMP WITH OFFICE STAMP↑

EXAMINATION DATE: _____

MAKE A COPY FOR YOUR CHILD'S HOME HEALTH FILE