



## 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:<br><input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection<br>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:<br><input type="checkbox"/> Heart murmur or heart infection<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease<br><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 <b>DURING</b> or <b>AFTER</b> 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. <b>FEMALES ONLY:</b> Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes: At what age was her first menstrual period? _____<br>How many periods has she had in the last 12 months? _____<br>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: _____<br>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:<br><input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome<br><input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems<br><input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease<br>Other: _____ |     |    |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:<br><input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome<br><input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia<br><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 ☐ No ☐

| Physical exam for grade:<br>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)

Parent/guardian present during exam: Yes ☐ No ☐Physical exam performed at: Personal Health Care Provider's Office ☐ School ☐ Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD ☐ DO ☐ PAC ☐ CRNP ☐

**HEALTH CARE PROVIDERS:** Please photocopy immunization history from student's record – OR – insert information below.

**IMMUNIZATION EXEMPTION(S):**

Medical ☐ Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

Medical ☐ Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

Medical ☐ Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

| VACCINE                                                                                 | DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization |    |    |    |    |
|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----|----|----|----|
| Diphtheria/Tetanus/Pertussis (child)<br>Type: DTaP, DTP or DT                           | 1                                                                              | 2  | 3  | 4  | 5  |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td                     | 1                                                                              | 2  | 3  | 4  | 5  |
| Polio<br>Type: OPV or IPV                                                               | 1                                                                              | 2  | 3  | 4  | 5  |
| Hepatitis B (HepB)                                                                      | 1                                                                              | 2  | 3  | 4  | 5  |
| Measles/Mumps/Rubella (MMR)                                                             | 1                                                                              | 2  | 3  | 4  | 5  |
| Mumps disease diagnosed by physician <input type="checkbox"/>                           | Date: _____                                                                    |    |    |    |    |
| Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>            | 1                                                                              | 2  | 3  | 4  | 5  |
| Serology: (Identify Antigen/Date/POS or NEG)<br>i.e. Hep B, Measles, Rubella, Varicella | 1                                                                              | 2  | 3  | 4  | 5  |
| Meningococcal Conjugate Vaccine (MCV4)                                                  | 1                                                                              | 2  | 3  | 4  | 5  |
| Human Papilloma Virus (HPV)<br>Type: HPV2 or HPV4                                       | 1                                                                              | 2  | 3  | 4  | 5  |
| Influenza<br>Type: TIV (injected)<br>LAIV (nasal)                                       | 1                                                                              | 2  | 3  | 4  | 5  |
|                                                                                         | 6                                                                              | 7  | 8  | 9  | 10 |
|                                                                                         | 11                                                                             | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib)                                                     | 1                                                                              | 2  | 3  | 4  | 5  |
| Pneumococcal Conjugate Vaccine (PCV)<br>Type: 7 or 13                                   | 1                                                                              | 2  | 3  | 4  | 5  |
| Hepatitis A (HepA)                                                                      | 1                                                                              | 2  | 3  | 4  | 5  |
| Rotavirus                                                                               | 1                                                                              | 2  | 3  | 4  | 5  |
| <b>Other Vaccines: (Type and Date)</b>                                                  |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |
|                                                                                         |                                                                                |    |    |    |    |

[illegible]