SHARON COMMUNITY SCHOOL
STUDENT'S PHYSICAL EXAMINATION REPORT
Physician's Report
(Please return this completed form to the School Nurse by December 31st of this school year.)

Student's Name_____ Sex _____ Birthdate_____

Height_____ Weight _____ Blood Pressure _____

LAB RESULTS: Urinalysis_____ Hgb _____ Hematocrit _____

Disability of Hearing _____ Extent _____ Corrected _____

Visual Acuity: R20/_____ L20/_____ Corrected R20/_____ L20/_____ Diabetes _____

Known Allergies _____

Asthma/Bronchitis _____ Seizure Disorders _____ Scoliosis _____

	Normal	**Abnormal or Comments**
EYES	_____/	_____
EARS	_____/	_____
NOSE	_____/	_____
THROAT	_____/	_____
TEETH	_____/	_____
SCALP AND SKIN	_____/	_____
HEART	_____/	_____
LUNGS	_____/	_____
ABDOMEN	_____/	_____
POSTURE	_____/	_____
ORTHOPEDIC AND FEET	_____/	_____
NERVOUS SYSTEM	_____/	_____
NUTRITION	_____/	_____
GLANDS	_____/	_____
THYROID	_____/	_____

PHYSICIAN'S COMMENTS AND/OR REFERRALS: _____
_____
_____

Have arrangements been made for further necessary medical attention: Yes_____ No _____

Is pupil capable of carrying full program of schoolwork? Yes_____ No _____

Should this student have any restrictions on physical education, athletics or other activity?

Yes _____ No _____ Explain _____

Are there any recommendations for follow- up, specific medical or surgical care?

Yes _____ No _____ Explain _____

PHYSICIAN'S SIGNATURE: _____**DATE:** _____

PHYSICIAN'S ADDRESS: _____ **PHONE:** _____