PHYSICAL EXAMINATION RECORD-PART 1

Name _____ Birth Date _____ Sex _____ Grade _____ Date _____
Home Address _____ School _____
Doctor's Name/tel.# _____ Dentist's Name/tel# _____

DOES YOUR CHILD HAVE:	YES/NO		YES/NO	DOES YOUR CHILD:	YES/NO
Allergies (including bee stings)	_____	Behavorial Problems?	_____	Have Trouble Seeing Close Work?	_____
Asthma?	_____	Alcohol/Drug Use?	_____	Seeing at a Distance?	_____
Diabetes?	_____			Wear Glasses?	_____
Ear Infections/Tonsillitis?	_____	**HAS YOUR CHILD HAD:**		Wear Contact Lenses?	_____
Epilepsy/Seizures?	_____	Childhood Diseases? (list)	_____	Have Trouble Hearing?	_____
Heart Conditions?	_____	Rheumatic Fever?	_____	Wear a Hearing Aid?	_____
Bone/Joint Problems?	_____	Scarlet Fever?	_____	Take Any Medication Regularly?	_____
Hernia?	_____	Tuberculosis?	_____	See an Orthodontist?	_____
Absent testicle/ovary/kidney/eye?	_____	Any Other Serious Illness?	_____		
Birth Defect/Deformity?	_____	Concussion?	_____		
Sickle Cell Trait?	_____	Serious Injury?	_____		
Skin Condition?	_____	Surgery?	_____		
Enlarged Liver/Spleen?	_____	Tuberculin Test?	_____		
High Blood Pressure?	_____	Chest X-Ray?	_____		

If Yes to any of the above, please explain (use an extra sheet if necessary) _____

_____

_____

_____

I certify that this information is accurate to the best of my knowledge. I also certify that my child is not being regularly treated by a physician for a heart condition, asthma, epilepsy, or any other chronic or serious condition requiring special care.

_____ _____
Parent (Guardian) Signature Date

TO BE COMPLETED BY PHYSICIAN ONLY

Name _____ School _____ Grade _____

Height _____ Weight _____ Pulse Rate _____ Blood Pressure _____

Vision: R-20/ _____ L-20/ _____ Corr. To R-20/ _____ L-20/ _____ Hearing: R-15 _____ L-15 _____

Heart _____ Neck _____ Chest/Lungs _____

Cardiovascular _____ Abdomen _____ Genitalia/hernia _____

Musculoskeletal _____ Neuropsychiatric _____

Glands _____ Teeth _____ Skin _____ Nutrition _____

Hemoglobin _____ Hematocrit _____ Urine: Sugar _____ Albumin _____

Are there any reasons why the pupil cannot carry a full program of school work? Yes _____ No _____
Is special seating recommended? Yes _____ No _____
Should special education or playground activities be restricted? Yes _____ No _____
(If yes to above answers, please comment:) _____

_____

_____ _____
Physician's Signature Date