ESU #8 SCHOOL HEALTH PHYSICAL FORM

Name_____ **School**_____

Address_____ **Date of Birth**_____

Parent or Guardian_____ **Phone (home)**_____ **(cell)**_____

Immunizations	Month/Day/Year	Given By:	Medical History	Yes	No	Comments:
DTaP/DTP/TD (Diphtheria-Tetaus-Pertussis)	1.		**Allergies**			
	2.					
	3.		**Asthma**			
	4.					
	5.		**Diabetes**			
	6.					
Polio (IPV, OPV)	1.		**Glasses/Vision Difficulties**			
	2.					
	3.		**Head Injury**			
	4.					
	5.		**Hearing Loss or Difficulties**			
MMR (Measles-Mumps-Rubella)	1.					
	2.		**Heart Problems**			
Hepatitis B	1.					
	2.		**Orthopedic Problems**			
	3.					
Varicella	1.		**Seizures**			
	2.					
HIB	1.		**Surgery**			
	2.					
	3.		**Current Medications / Dose / Reason:**			
Other						

I give my consent to share this information with school personnel. *Parent Signature*_____ *Date*_____

PHYSICAL EXAMINATION

General Appearance_____ Height_____ Weight_____
Nutrition_____ Skin_____
Skeletal Development_____ Scoliosis_____
Lymph Nodes_____

HEAD
Scalp_____
Eyes_____
Ears_____ Hearing_____
Nose_____
Throat/Tonsils_____

Vision
** For kindergarten students, please use the attached form.*

	R	L
1. Without correction	_____	_____
2. With correction	_____	_____

NECK Thyroid_____

CHEST Heart_____ Size_____ Rate_____ Rhythm____ BP_____

ABDOMEN Viscera_____ Liver_____ cm_____
Her_____ Genitals_____

EXTREMITIES Upper_____ Lower_____

NEUROLOGICAL _____

LAB TESTS Urinalysis_____ Hematocrit_____
Other_____

RECOMMENDATIONS Physical Activity (circle one): Unrestricted Moderate Minimum
Remarks and Suggestions:

_____ _____ _____
Printed Name/Clinic *Signature of M.D./P.A./A.P.R.N.* *Date of Exam*