PHYSICAL EXAMINATION

(New Students, PreK, Kindergarten, Grade 6, Grade 11, and Grades 6-12 Athletics)

Student Name _____ Birthdate_____ Grade_____

Address _____

Home Phone _____

REQUIRED IMMUNIZATIONS: New students must complete in full. Current students, record what is administered today. Please use grid or attach copy of immunization record.

VACCINE	DOSES: Enter month, day, and year each immunization was given.				
Diphtheria and Tetanus (DtaP, DTP, Td or DT)	1. / /	2. / /	3. / /	4. / /	5. / /
Tetanus, Diphtheria and Acellular Pertussis (Tdap)*	1. / /	2. / /	3. / /	4. / /	5. / /
Hepatitis B	1. / /	2. / /	3. / /	4. / /	5. / /
Measles-Mumps-Rubella (MMR)	1. / /	2. / /	Or Measles Serology:	Date _____	Titer _____
Varicella (vaccine or disease)	1. / /	2. / /	Rubella Serology:	Date _____	Titer _____
Polio (OPV or IPV)	1. / /	2. / /	3. / /	4. / /	5. / /
Meningococcal (MCV)*	1. / /	2. / /	Mumps disease diagnosed by a physician:	Date _____	
Other	1. / /	2. / /			

Age appropriate dose of MCV and Tdap are required for entry into Grade 7.

Students entering PreK, Kindergarten, or Grade 1 for the first time, or entering school in the State of Pennsylvania for the first time must have a tuberculin test within six months prior to admission, and Grade 9.

TUBERCULIN TEST DATE _____ **RESULT** _____

Physician Verification _____

CURRENT HEALTH CONDITIONS	YES	NO	IF YES, PLEASE EXPLAIN.
Allergies	❍	❍	_____
Epinepherine needed?	❍	❍	
Permission to self-carry? (MS/US only)	❍	❍	*Please complete and forward Anaphylaxis Plan to School Nurse.*
Permission to self-administer?	❍	❍	
Asthma	❍	❍	_____
Carries inhaler?	❍	❍	*Please complete and forward Asthma Action Plan to School Nurse.*
Permission to self-administer?	❍	❍	
Cardiac	❍	❍	_____
Depression/Anxiety	❍	❍	_____
Diabetes	❍	❍	*Please complete and forward School Health Care Plan: Diabetes to School Nurse.*
Gastrointestinal Disorder	❍	❍	_____
Respiratory Illness	❍	❍	_____
Hypertension	❍	❍	_____
Neuromuscular Disorder	❍	❍	_____
Seizure Disorder	❍	❍	*Please complete and forward Seizure Action Plan to School Nurse.*
Current Medications	❍	❍	_____

PHYSICAL EXAMINATION

A thorough health history should be completed prior to the exam. Date of Examination _____

Student Name _____ Birthdate _____ Grade _____

Height _____ Weight _____ BMI # _____ / _____ % _____ Body Fat (optional) _____

Is this BMI in recommended range? ❍ Yes ❍ No

Was counseling initiated? ❍ Yes ❍ No

Pulse _____

BP _____ / _____ (_____ / _____ , _____ / _____)

Vision R 20 / _____ L 20 / _____ Corrected: ❍ Yes ❍ No Pupils: ❍ Equal ❍ Unequal

MEDICAL	NORMAL	ABNORMAL FINDINGS	NOT EXAMINED
Appearance	❍	_____	❍
Eyes/Ears/Nose/Throat	❍	_____	❍
Lymph Nodes	❍	_____	❍
Heart – Murmur, etc.	❍	_____	❍
Pulses	❍	_____	❍
Lungs – Adventitious Finding	❍	_____	❍
Abdomen	❍	_____	❍
Skin	❍	_____	❍
MUSCULOSKELETAL			
Neck	❍	_____	❍
Back (Scoliosis Screening)	❍	_____	❍
Shoulder/Arm	❍	_____	❍
Elbow/Forearm	❍	_____	❍
Wrist/Hand	❍	_____	❍
Hip/Thigh	❍	_____	❍
Knee	❍	_____	❍
Leg/Ankle	❍	_____	❍
Foot	❍	_____	❍

CLEARANCE

❍ Cleared for all sports without restrictions

❍ Cleared for all sports without restrictions with recommendations for further evaluation or treatment for: _____

_____

❍ Not cleared pending further evaluation. Reason: _____

_____

Recommendations: _____

Signature of Physician: _____ Signature Date: _____

Print name of Physician: _____