HS0020
526009
Rev. 1/07

PHYSICAL EXAMINATION REQUIREMENTS

"The Board of Education shall require evidence of a physical examination by a physician, physician assistant, or an advanced practice registered nurse within six months prior to the entrance of a child into the beginner grade and the seventh grade, or in the case of a transfer from out-of-state to any other grade of the local school; provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing." A complete visual evaluation is required at the entry grade (kindergarten, or grade of transfer from out of state). A vision professional may also complete the required visual evaluation. Waiver forms are available in each school health office. School Law 79-214 (3). Physical examinations are recommended at the third and tenth grade in addition to the required examinations.

Name ______________________ School BLESSED SACRAMENT SCHOOL Grade ________

Address ______________________ Zip ________ Age ________ Sex: M ______ F ______

Physician ______________________

PHYSICAL FINDINGS

Height ______________ Weight ______________

Blood Pressure ______________ Pulse ______________

Urinalysis ______________________

Hemoglobin/Hct ______________________

Audiometric Screening Report, if given

	500	1000	2000	4000
RE				
LE				

Immunizations given during today's visit:

DTP____ Td____ polio____ MMR____ Hib____ Hep B____

Varicella ____ other (list) ______________________

(Please attach copy of immunization record on file.)

Significant findings/Chronic Health Problems (please review health history)

____

	PASS	FAIL	RECOMMEND FURTHER EVALUATION (see comments below)
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity			

20 feet: Right 20/___ Left 20/___ with/without glasses

16 inches: Right 20/___ Left 20/___ with/without glasses

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart (note murmur if present)		
Pulses (inc. Femoral)		
Lungs		
Abdomen		
Skin		
MUSCULOSKELETAL		
Neck		
Spine		
Shoulder/arm		
Wrist/hand		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot		
Evidence of Scoliosis no ______ yes ______		
Evidence of Hernia no ______ yes ______		
Stigmata of Marfan's Syndrome no ______ yes ______		

Required medication on a daily or episodic routine ______________________

Please check classification

- ❑ Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related activities without undue risk or injury.
- ❑ Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Reexamine each year.
- ❑ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. These students should be re-examined for possible reclassification at the end of the exemption period.

Please check certification

- ❑ Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic athletics.
  Activities student should **not** participate in ______________________

Recommendations: ______________________

Your signature below indicates completion of physical exam and review of health history.

Date ____________ Signed ______________________, M.D.
Examining Physician (Signature Required)

Clinic/Practice Name *(please print)* ______________________

Physician Address ______________________ Physician Phone ____________

Return to School Health Office