



Report of Physical Examination

School: _____ Grade: _____ Gender: _____
 Name: _____ DOB: _____ Age: _____
 Address: _____ Phone: _____
 City: _____ State: _____ Zip: _____

Physical Findings

Date of Exam:	Height:	Weight:
BP:	Pulse:	Skin:
Scalp:	Teeth:	Gums:
Nutrition:	Eyes:	Ears:
Nose:	Throat:	Lymph:
Lungs	Heart:	Abdomen:
Ortho:	Reflexes:	Genitalia:
Scoliosis:		

SIGNIFICANT CONCERNS:

IMMUNIZATIONS: *Please attach immunization record.*

Can pupil carry a full program of schoolwork? No Yes

Should physical activity be restricted? No Yes *(If yes, please explain below.)*

Is this child on daily medication? No Yes *(If yes, complete section below.)*

Medication: _____ Dosage: _____ Schedule: _____

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Medication: _____ Dosage: _____ Schedule: _____

Physician Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Physician Signature: _____ **Date:** _____