Physical Exam - TO BE COMPLETED BY EXAMINER

ALLERGIES: ☐ Food _____ ☐ Insects _____ ☐ Medication_____ ☐ **LIFE THREATENING**

Vision/Hearing

Without glasses/contact lenses	**R**	**L**
With glasses/contact lenses	**R**	**L**
Hearing	**R**	**L**

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

	Normal	Abnormal/Comments
General Appearance		
Nutrition/ Body Mass Index		
Skin		
Head		
Eyes		
Ears		
Nose, Throat and Teeth		
Lymph Nodes/Thyroid		
Lungs		
Heart		
Abdomen		
Genitalia		Tanner: I. II. III. IV. V
Musculoskeletal		**Scoliosis:** Negative Positive
Neurological		

Physical Education/Sports Consideration

☐ **Physically qualified for sports or full physical education OR only as checked below:**
___ Contact collision (football, soccer, wrestling, basketball, field hockey, lacrosse, water polo, ice hockey)
___ Limited contact (baseball, cheerleading, softball, volleyball, track and field)
___ Non-contact strenuous (running, tennis, dancing, golf, jumping rope, swimming, walking, weight lifting)

☐ **Known or suspected disability:** _____

☐ **Restrictions/Recommendations:** _____

☐ **Referral for further evaluation:** _____

Physician/Provider's Signature: _____ **Date of Exam:** _____
Physician/Provider's Name (print): _____ Phone: _____

DAILY MEDICATIONS

Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____
Name: _____ Dosage/Time: _____

OTC MEDICATION DISTRIBUTION AT SCHOOL

OTC MEDICATIONS MAY be given by the School Nurse at her discretion when the student requests. All medications will be given as directed by the manufacturer and ONLY WITH PARENT CONSENT:

☐ Acetaminophen ☐ Ibuprofen ☐ Benadryl ☐ Midol ☐ Antacid Tablets ☐ Nasal Decongestant

PARENT:
I give permission for my child to receive medication or therapy in school:
PARENT SIGNATURE: _____ **Date:** _____