PLEASE RETURN THIS FORM BY AUGUST 1, 2024

Student's name, last, first | Grade | Date of birth | Date of examination (after 8/1/23)

Physician's Examination Part 1

Height_____ Weight_____Blood Pressure_____Pulse Rate_____

Please Circle N (normal) or A (abnormal)

N A Eyes _____
Visual Acuity R/_____ L/_____
N A Ears _____
Hearing R/_____ L/_____
N A Respiratory _____
N A Cardiovascular _____
N A Spine _____
N A Gastrointestinal _____
N A Genitourinary _____
N A Neuro _____

Completion of Immunization Certificate is Required

Physician's Examination Part 2

Please answer each question yes or no. If yes, describe the problem and any medication or treatment required.

Y N Significant health history/physical findings/current conditions_____

_____

Y N Has this student ever received medical attention for head injury or concussion? _____

Y N Are there any restrictions placed on physical activity? _____

Y N Are there any psychological/physical issues which may interfere with performance at school? _____

_____

Y N Any Medications? _____

Y N Known allergies: food/insect stings/medications? _____

Y N Epi-pen indicated? If yes, complete an allergy action plan and provide the school with epi-pen

Y N Asthma? If yes, what medication/treatment is required? _____

Y N Student may self-administer inhaler in grades 5 and above _____

Y N Student may self-administer epi-pen in grades 5 and above _____

I find this student physically able to participate in physical education class (Kindergarten through 12th grade), strenuous sports, including intramural and interscholastic (5th through 12th grade), subject to limitations or restrictions noted, for the 2024-2025 school year:_____

_____

_____ _____ _____

Physician's signature and date | Physician's printed name | Physician's telephone