PHYSICAL EXAMINATION (School year: Grade:)

For use only by new students or those entering Grade 6 or 9

To be completed by **physician.**

Student name: _____ Gender: ☐M ☐F Date of Birth (m/d/y) :_____

•Height _____Weight _____ Temp _____ Pulse _____ BP _____/_____

•Visual acuity: R _____/20_(____)_ L _____/20_(____)_ Wears glasses/contacts: ☐Yes ☐No

•General Nutrition: ☐Excellent ☐Good ☐Fair ☐Poor

•Significant Weight loss in past year ☐Yes ☐No If "yes," how much? _____

PLEASE EXAMINE AND CHECK (✓) EACH AREA

Please examine and check each area	Normal	Abnormal	Describe Abnormal Findings
Skin/Scalp			
Eyes			
Ears: otoscopic			
hearing			
Nose			
Throat			
Lymph Nodes			
Thyroid			
Heart			
Lungs			
Abdomen: hernia, masses, other			
Gentio-urinary			
Musculoskeletal: deformity			
limitation			
swelling/tenderness			
Scoliosis screening			
Neurological			
Other			
Uranalysis (if indicated)			
Hemoglobin/Hematocrit (if indicated)			
Additional omments and recommendations:			

TUBERCULOSIS SCREENING • REQUIRED OF NEW STUDENTS AND SIXTH GRADERS

(to be completed by physician-refer to Tuberculosis Screening Risk Factor Questionnaire)

BCG immunization: ☐Yes ☐No If "yes," record dates given _____

Results of TB Risk Factor Questionnaire- Does student need PPD or Chest x-ray? ☐Yes ☐No

<u>If YES</u> to risk factors or symptoms please perform TB screening by PPD or Chest x-ray.

PPD results: Date given _____ Date read _____ Results _____ mm of induration

Chest x-ray results: Date _____ Results _____

Please review immunization records and update immunizations if needed:

Type_____Date (m/d/y) _____

Type_____Date (m/d/y) _____

Based on the above history and physical, this student:

☐ **YES**-is cleared for participation in competitive athletics and physical education activities.

☐ **NO**-is not cleared for participation in athletic activities due to _____

Physician Signature _____ **Date** (m/d/y) _____

Medical facility/physician seal:

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