ANNUAL PHYSICAL EXAMINATION

To be completed by a qualified licensed physician, nurse practitioner, or physician assistant. The exam is required annually, to be completed within one year of the start of the school year.

Student Name:________________________ Date of Birth:________________ Sex: ❑ M ❑ F

Health History

❑ No health history	❑ **Known health history - select all that apply:**	**Comments:**
	❑ heart condition ❑ concussion / head injury ❑ chronic respiratory disease	
	❑ diabetes (type 1 or 2) ❑ severe asthma (regular use of inhaler) ❑ cancer	
	❑ regular steroid treatment ❑ neurological disease ❑ immunosuppression	
	❑ kidney disease ❑ obesity (BMI>30) ❑ liver disease ❑ Down syndrome ❑ other	

Concerns	Status	If Yes, provide further details
Allergies	❑ Yes ❑ Not applicable	
Current Medication	❑ Yes ❑ Not applicable	

Physical Examination

Pulse / Temperature	Blood Pressure	Weight	Height	Body Mass Index (BMI)
Pulse: ________ Temp: ________ °F / °C	_____ / _____	❑ LB ❑ KG	❑ IN ❑ CM	

	Normal	Abnormal	Not Assessed		Normal	Abnormal	Not Assessed
Growth / nutrition				Eyes			
Met developmental milestones				Cardiovascular			
Speech / communication				Chest / respiratory			
Skin / hair				Abdomen / gastrointestinal			
Head / neck				Orthopedic / posture			
Teeth				Nervous system			
Ears / nose / throat				Urogenital			

Screenings

Note: Hearing, vision and dental screenings to be completed by the family doctor. If not possible, check "Unable to test".

Vision Screening ❑ Unable to test	Left eye: 20 / ________ ❑ Corrected / ❑ Uncorrected	Right eye: 20 / ________ ❑ Corrected / ❑ Uncorrected	**Dental Screening** ❑ Unable to test ❑ Referred for treatment
Hearing Screening ❑ Unable to test	❑ Pass ❑ Fail ❑ Uses Device ❑ Referred		❑ Referred for prevention ❑ Already receiving care; no referral

Tuberculosis (TB) Screening

If no risk is identified, additional testing is not required.

❑ No risk or symptoms for TB identified	If risk is identified, indicate test completed, results and follow up:
❑ Risk for TB infection/symptoms identified	

Physical Activity

Is able to:	Yes	No	N/A	If No, provide further details
Participate in sports?				
Participate in physical education?				
Free of physical limitations?				

Immunizations

❑ Immunizations up-to-date ❑ Immunizations needed: ________________________

Medical Provider (Write legibly or stamp)

❑ By checking this box, I certify that all of the information entered above is accurate.

Name:________________________ Signature:________________ Date:____________