



Bureau of Community Health Systems  
Division of School Health

**Private or School  
PHYSICAL EXAMINATION  
OF SCHOOL AGE STUDENT**

**PARENT / GUARDIAN / STUDENT:**

Complete page one of this form **before** student's exam. Take completed form to appointment.

Student's name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of birth \_\_\_\_\_ Age at time of exam \_\_\_\_\_ Gender:  Male  Female

**Medicines and Allergies:** Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

\_\_\_\_\_

Does the student have any allergies?  No  Yes (If yes, list specific allergy and reaction.)

Medicines  Pollens  Food  Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

| GENERAL HEALTH: <i>Has the student...</i>   | YES | NO |
|---|-----|----|
| 1. Any ongoing medical conditions? If so, please identify:<br><input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection<br>Other _____   |     |    |
| 2. Ever stayed more than one night in the hospital?   |     |    |
| 3. Ever had surgery?  |     |    |
| 4. Ever had a seizure?  |     |    |
| 5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?  |     |    |
| 6. Ever become ill while exercising in the heat?  |     |    |
| 7. Had frequent muscle cramps when exercising?  |     |    |
| HEAD/NECK/SPINE: <i>Has the student...</i>  | YES | NO |
| 8. Had headaches with exercise?   |     |    |
| 9. Ever had a head injury or concussion?  |     |    |
| 10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?   |     |    |
| 11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?  |     |    |
| 12. Ever been unable to move arms or legs after being hit or falling?   |     |    |
| 13. Noticed or been told he/she has a curved spine or scoliosis?  |     |    |
| 14. Had any problem with his/her eyes (vision) or had a history of an eye injury?   |     |    |
| 15. Been prescribed glasses or contact lenses?  |     |    |
| HEART/LUNGS: <i>Has the student...</i>  | YES | NO |
| 16. Ever used an inhaler or taken asthma medicine?  |     |    |
| 17. Ever had the doctor say he/she has a heart problem? If so, check all that apply:<br><input type="checkbox"/> Heart murmur or heart infection<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____ |     |    |
| 18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?   |     |    |
| 19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?  |     |    |
| 20. Had discomfort, pain, tightness or chest pressure during exercise?  |     |    |
| 21. Felt his/her heart race or skip beats during exercise?  |     |    |
| BONE/JOINT: <i>Has the student...</i>   | YES | NO |
| 22. Had a broken or fractured bone, stress fracture, or dislocated joint?   |     |    |
| 23. Had an injury to a muscle, ligament, or tendon?   |     |    |
| 24. Had an injury that required a brace, cast, crutches, or orthotics?  |     |    |
| 25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?  |     |    |
| 26. Had joints that become painful, swollen, feel warm, or look red?  |     |    |
| SKIN: <i>Has the student...</i>   | YES | NO |
| 27. Had any rashes, pressure sores, or other skin problems?   |     |    |
| 28. Ever had herpes or a MRSA skin infection?   |     |    |

| GENITOURINARY: <i>Has the student...</i>  | YES | NO |
|---|-----|----|
| 29. Had groin pain or a painful bulge or hernia in the groin area?  |     |    |
| 30. Had a history of urinary tract infections or bedwetting?  |     |    |
| 31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes: At what age was her first menstrual period? _____<br>How many periods has she had in the last 12 months? _____<br>Date of last period: _____  |     |    |
| DENTAL:   | YES | NO |
| 32. Has the student had any pain or problems with his/her gums or teeth?  |     |    |
| 33. Name of student's dentist: _____<br>Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years   |     |    |
| SOCIAL/LEARNING: <i>Has the student...</i>  | YES | NO |
| 34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?  |     |    |
| 35. Been bullied or experienced bullying behavior?  |     |    |
| 36. Experienced major grief, trauma, or other significant life event?   |     |    |
| 37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?   |     |    |
| 38. Been worried, sad, upset, or angry much of the time?  |     |    |
| 39. Shown a general loss of energy, motivation, interest or enthusiasm?   |     |    |
| 40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?  |     |    |
| 41. Used (or currently uses) tobacco, alcohol, or drugs?  |     |    |
| FAMILY HEALTH:  | YES | NO |
| 42. Is there a family history of the following? If so, check all that apply:<br><input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome<br><input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems<br><input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder<br><input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease<br>Other _____ |     |    |
| 43. Is there a family history of any of the following heart-related problems? If so, check all that apply:<br><input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome<br><input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____                   |     |    |
| 44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?   |     |    |
| 45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?   |     |    |
| QUESTIONS OR CONCERNS   | YES | NO |
| 46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)  |     |    |

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT'S HEALTH HISTORY** (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes  No

| Physical exam for grade:<br>K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/> | CHECK ONE |           |       | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
|--|-----------|-----------|-------|--|
|  | NORMAL    | *ABNORMAL | DEFER |  |
| Height: ( ) inches   |           |           |       |  |
| Weight: ( ) pounds   |           |           |       |  |
| BMI: ( )   |           |           |       |  |
| BMI-for-Age Percentile: ( ) %  |           |           |       |  |
| Pulse: ( )   |           |           |       |  |
| Blood Pressure: ( / )  |           |           |       |  |
| Hair/Scalp   |           |           |       |  |
| Skin   |           |           |       |  |
| Eyes/Vision Corrected <input type="checkbox"/>   |           |           |       |  |
| Ears/Hearing   |           |           |       |  |
| Nose and Throat  |           |           |       |  |
| Teeth and Gingiva  |           |           |       |  |
| Lymph Glands   |           |           |       |  |
| Heart  |           |           |       |  |
| Lungs  |           |           |       |  |
| Abdomen  |           |           |       |  |
| Genitourinary  |           |           |       |  |
| Neuromuscular System   |           |           |       |  |
| Extremities  |           |           |       |  |
| Spine (Scoliosis)  |           |           |       |  |
| Other  |           |           |       |  |

| TUBERCULIN TEST | DATE APPLIED | DATE READ | RESULT/FOLLOW-UP |
|-----------------|--------------|-----------|------------------|
|                 |              |           |                  |
|                 |              |           |                  |

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**  
 (Additional space on page 4)

Parent/guardian present during exam: Yes  No

Physical exam performed at: Personal Health Care Provider's Office  School  Date of exam \_\_\_\_\_ 20\_\_\_\_

Print name of examiner \_\_\_\_\_

Print examiner's office address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of examiner \_\_\_\_\_ MD  DO  PAC  CRNP

**HEALTH CARE PROVIDERS:** Please photocopy immunization history from student's record – OR – insert information below.

**IMMUNIZATION EXEMPTION(S):**

Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_  
 Medical  Date Issued: \_\_\_\_\_ Reason: \_\_\_\_\_ Date Rescinded: \_\_\_\_\_

**NOTE:** The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

| VACCINE   | DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization |    |    |    |    |
|---|--|----|----|----|----|
|   | 1  | 2  | 3  | 4  | 5  |
| Diphtheria/Tetanus/Pertussis (child)<br>Type: DTaP, DTP or DT                           |  |    |    |    |    |
| Diphtheria/Tetanus/Pertussis (adolescent/adult)<br>Type: Tdap or Td                     |  |    |    |    |    |
| Polio<br>Type: OPV or IPV   |  |    |    |    |    |
| Hepatitis B (HepB)  |  |    |    |    |    |
| Measles/Mumps/Rubella (MMR)   |  |    |    |    |    |
| Mumps disease diagnosed by physician <input type="checkbox"/>                           | Date: _____  |    |    |    |    |
| Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>            |  |    |    |    |    |
| Serology: (Identify Antigen/Date/POS or NEG)<br>i.e. Hep B, Measles, Rubella, Varicella |  |    |    |    |    |
| Meningococcal Conjugate Vaccine (MCV4)  |  |    |    |    |    |
| Human Papilloma Virus (HPV)<br>Type: HPV2 or HPV4                                       |  |    |    |    |    |
| Influenza<br>Type: TIV (injected)<br>LAIV (nasal)                                       | 6  | 7  | 8  | 9  | 10 |
|   | 11   | 12 | 13 | 14 | 15 |
| Haemophilus Influenzae Type b (Hib)   |  |    |    |    |    |
| Pneumococcal Conjugate Vaccine (PCV)<br>Type: 7 or 13                                   |  |    |    |    |    |
| Hepatitis A (HepA)  |  |    |    |    |    |
| Rotavirus   |  |    |    |    |    |
| <b>Other Vaccines: (Type and Date)</b>  |  |    |    |    |    |
|   |  |    |    |    |    |
|   |  |    |    |    |    |
|   |  |    |    |    |    |
|   |  |    |    |    |    |

