TRADITION.
INNOVATION.
EXCELLENCE.

STUDENT PHYSICAL EXAM FORM

(PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF PUPIL OF SCHOOL AGE)

This form is required for each student upon their **enrollment** at Providence Heights Alpha School and their entrance into **kindergarten and sixth (6th) grade**. This form must be completed **prior to the beginning of the school year**. This form is required by the state of Pennsylvania and will be kept on file in the nurse's office.

PARENT TO FILL IN LINES 1—5

1. Name of Student:____

2. School:____________________ Grade:________ Date of Birth:____________

3. Parent/Guardian Name:____________________ Parent/Guardian Name:____________________

4. Phone Number:________________ (Home) ________________ (Cell) ________________ (Work)

5. Primary Address: ____

PHYSICIAN TO FILL IN LINES 5—9

6. IMMUNIZATIONS: Please attach a form listing the dates of ALL immunizations and boosters given.

7. MEDICAL HISTORY

Health History & Medical Information Pertinent to routine care and diagnosis/treatment in case of an emergency (please specify): ____________________

Describe all medication and any special diet received and the reason for them (please list All medications for emergency purposes): ____________________

Allergies (please specify):____

Hospitalizations/Surgery/Accidents/Serious Illness (please specify):____________________

List any health problems or special needs and recommended treatment/services. Describe the plan for care that should be followed including indication of special training required for staff, equipment and provision for emergencies. (attach additional sheets as needed): ____________________

8. REPORT OF EXAMINATION *Please elaborate below on "abnormal" findings

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Nutrition			Glands			Skeleton		
Skin			Heart			Scoliosis-Bending Position		
Eyes/Vision			Lungs			Emotional Status		
Ears/Hearing			Abdomen			Height/Weight		
Nose & Throat			Genitalia			BP/Pulse		
Teeth & Gingiva			Neuro Muscular System			Wears Corrective Lens: ☐Yes ☐ No		
Abnormal Findings:								

TURN PAPER OVER

Has the child received all age appropriate screenings listed in the routine preventative health care services currently recommend by the American Academy of Pediatrics? ☐ No (if no, please explain) ☐ Yes

If the results of vision, hearing, or lead screenings were abnormal, provide the date the screening was completed and information about referrals, implications or actions recommended below:

Vision: ____

____

____

Hearing: ____

____

____

Lead: ____

____

____

9. RESTRICTIONS

Should this child have restrictions on any play, swim, or physical education activities? ☐ No ☐ Yes (if yes, please explain)

____

In your assessment, is the child able to participate in child care and does the child appear free from contagious or communicable diseases?
☐ No (if no, please explain) ☐ Yes

____

10. RECOMMENDATIONS

What recommendations do you wish to make to the teacher or school nurse, which might be of benefit to this child?

____

Date of Examination:__________________ Signature of Physician:______________________________

Physician Name:____________________________ Physician Phone:______________________________

Physician Address:____

License Number: ____________________________