



Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): inches ( %)	Skin			
Weight (light clothing): lbs. oz. ( %)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATION RECORDS OR MEDICAL EXEMPTION FROM VACCINES (yearly) MUST BE SUBMITTED TO SCHOOL: COMPLETED FOR AGE OF STUDENT AND APPROVED IN ORDER TO COMPLETE ENROLLMENT**

Immunizations Submitted: Yes  No   
 Immunizations Approved: Yes  No   
 Notes:

HEARING SCREEN DATE:

	1 <sup>st</sup> screening		Hearing Screening	2 <sup>nd</sup> screening		1 <sup>st</sup> Vision Screening	2 <sup>nd</sup> Vision Screening
	R	L		R	L		
at 25 dB			at 25 dB			Distance Acuity:	Distance Acuity:
1000 HZ			1000 Hz			R20/ ____ L-20/ ____	R-20/ ____ L-20/ ____
2000 Hz			2000 Hz			Pass ____ Refer ____	Pass ____ Refer ____
4000 Hz			4000 Hz			Fail ____	Fail ____
						Signature:	Signature:

Spinal Screening: Pass \_\_\_\_ Fail \_\_\_\_ Refer \_\_\_\_ Comments: \_\_\_\_\_

Patient Health History, Findings and Recommendations: \_\_\_\_\_

Physical Activity: Restricted or Unrestricted (circle one) Explanation: \_\_\_\_\_  
 \_\_\_\_\_

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
 (Stamped signature not accepted)

Please print physician's name and address: \_\_\_\_\_  
 (MD / DO or PA or RNP working under the direction of a licensed physician)