

Glens Falls City School District
Glens Falls, New York
STUDENT PHYSICAL EXAMINATION RECORD

Sports Physical Yes / No Sport: _____
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Date: _____

School: _____

<u>Student's Last Name</u>	<u>Student's First Name</u>	<u>DOB</u>	<u>Age</u>	<u>Sex</u>	<u>Grade</u>
<u>Parent's Name</u>			<u>Work Phone</u>		
<u>Home Address</u>		<u>Home Phone</u>		<u>Cell Phone</u>	

PLEASE LIST ALL INFECTIONS OR CONDITIONS YOUR CHILD HAS HAD:

Chronic Illnesses: Asthma Diabetes Type 1 Type 2 Hyperlipidemia Hypertension Other: _____

Surgeries: _____

Allergies: Y N Medications: _____

Foods: _____ Other: _____

Does your child require a special diet? Y N Describe: _____

Does your child take medication regularly? Y N List Meds: _____

Are there any side effects we should be aware of? Describe: _____

Are there any restrictions to physical education? Y N Describe: _____

Antigen	First Date	Second Date	Third Date	Fourth Date	Fifth Date
Hep B/Hib					
Dtap					
Polio					
MMR			XXXXXXXX	XXXXXXXX	XXXXXXXX
Hib					
Hep B				XXXXXXXX	XXXXXXXX
Varicella					
Prevnar					
Td					
Other					

Body Mass Index: _ . _
<input type="checkbox"/> Less than 5 th
<input type="checkbox"/> 5 th through 49 th
<input type="checkbox"/> 50 th through 84 th
<input type="checkbox"/> 85 th through 94 th
<input type="checkbox"/> 95 th through 98 th
<input type="checkbox"/> 99 th and higher

PHYSICAL EXAMINATION

N=Normal X=Defect

Height (inches): _____ Weight (lbs): _____ BMI: _____

BP: _____ Pulse: _____ General Appearance: _____

Eyes (Visual Acuity): R _____ L _____

With Glasses/Contacts: R _____ L _____

Ears (Hearing): R _____ L _____

Otoscope: R _____ L _____

Nutrition: _____

Lungs: _____

Nose: _____

Heart: _____

Spine: _____ Scoliosis? Y N

Murmur: _____

Dental: _____

Rhythm: _____

Orthodontic: _____

Abdomen: _____

Throat: _____

Hernias: _____

Speech: _____

Genitourinary: _____

Skin: _____

Nervous System: _____

Glands: _____

Epilepsy: _____

Behavioral/Psych: ADD _____ OCD _____ ODD _____

Other: _____

Other: _____

Any modifications to school program? Y N Comments: _____

Any restrictions to physical education? Y N Comments: _____

Special Services? Y N Comments: _____

Physician's Comments: _____

Physician's Signature: _____ Date: _____ Phone: _____

(If additional space is needed, please use back of form.)