

COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Student's Name _____ Date of Birth _____

Health Assessment

Weight: _____ Height: _____	Hearing Acuity: (R) _____ (L) _____ <input type="checkbox"/> Hearing aid or other assistive device
BP: _____ HR: _____ RR: _____	Visual Acuity: (R) _____ (L) _____ <input type="checkbox"/> Wears glasses

Current Medications: (Please list dosage and frequency)

Exam Results (WNL=within normal limits) otherwise describe:

HEENT	Abdomen
Teeth	Extremities
Heart	Skin
Lungs	Genitalia
Neurological	Urinary

Developmental Screening (WNL=within normal limits) otherwise describe:

Emotional/Social
Fine Motor
Language/Communication
Gross Motor

If Down Syndrome: Atlantoaxial subluxation? _____ (Y/N) Date of x-ray? (if applicable) _____

Date of last dental examination: _____

Serious illness/injury in past 3 years: (specify with dates) _____

Recommendations to School Personnel

Summary of Findings (check one):

- Well child; no conditions identified of concern to school program activities
- Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____

Allergy food(s): _____ insect: _____ medicine: _____ other: _____
Type of allergic reaction: anaphylaxis local reaction Response required: none epi-pen other _____

Emergency Health Plan needed (i.e. asthma, seizure disorder, severe allergy, etc.)

Restricted Activity: Specify _____

Developmental Evaluation Has IEP Further evaluation needed for: _____

Medication. Child takes medicine for specific health condition(s). Medication must be given and/or available at school

Special Diet Specify: _____

Special Needs (procedures, etc) Specify: _____

Signature of physician, nurse practitioner, or physician's assistant: _____

Date of examination: _____ Phone No. _____