

COMPREHENSIVE PHYSICAL EXAMINATION REPORT

Student's Name _____ Date of Birth _____

Health Assessment

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