GLEN ROCK PUBLIC SCHOOLS

PHYSICAL EXAMINATION

Examination of: _____ DOB: _____ Gender: _____

Height ___ft. ____in Weight ____lbs. BP _____ General Appearance: _____

Nutrition: _____ Skin: _____

Posture: _____ Scoliosis *(age appropriate)*: _____

Eyes: _____ Ears: _____

Nose: _____ Mouth: _____

Teeth: _____ Appliance: _____ Gums: _____

Throat: _____ Tonsils: _____

Glands: _____ Heart: _____

Lungs: _____ Extremities: _____

Abdomen: _____ Hernia: _____

Tanner Stage: _____ Speech: _____

Allergies: Type: _____ Asthma: _____ Normal Peak Flow: _____

Medications taken for above: _____

_____

Anaphylaxis History: _____

Immunizations: Record attached: _____ Received today: _____

Vision Screening: Right – 20/ _____ Left – 20 _____ Corrected _____ Uncorrected _____

Audiometric Screening: Right - _____ Left - _____

Behavioral Issues/Mental health Diagnosis/hyperactivity, lethargy, gait, etc.: _____

_____

Student may/may not participate in all normal school activities, including physical education: Yes: _____ No _____

RESTRICTIONS: _____

SPECIAL NEEDS: _____

_____ _____

Medical Provider's Signature ***Printed Name/Stamp Address/Telephone***

Date of Examination: _____

* I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature. I hereby authorize the release of pertinent medical information to be shared with appropriate professional staff involved in the care of my child.

_____ _____

Parent/Guardian Signature ***Date***