

PHYSICAL EXAMINATION REQUIREMENTS

Health Services Department

Logan View Public Schools

“The Board of Education shall require evidence of a physical examination by a physician, physician assistant, or an advanced practice registered nurse within six months prior to the entrance of a child into the beginner grade or in the case of a transfer from out-of-state to any other grade of the local school; provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing.”

Name _____ School _____ Grade _____

Address _____ Zip _____ Age _____ Sex: M ___ F ___

Height _____ Weight _____
 Blood Pressure _____ Pulse _____
 Urinalysis _____
 Hemoglobin/Hct _____
 Audiometric Screening Report, if given _____

	500	1000	2000	4000
RE				
LE				

Immunizations given during today's visit:

DPT ___ Td ___ polio ___ MMR ___ Hib ___ Hep B ___

Varicella ___ other (list) _____

(Please attach copy of immunization record on file)

Physical Findings

Medical	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart (note murmur If present)		
Pulses (inc. Femoral)		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Neck		
Spine		
Shoulder/arm		
Wrist/hand		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot		
Hip/thigh		

Evidence of Scoliosis no _____ yes _____
Evidence of Hernia no _____ yes _____
Stigmata of Marfan's Syndrome no _____ yes _____

Required medication on a daily or episodic routine _____

Please check classification:

___ Regular: Student may participate in the regular program of physical education, recreation, Intramurals, athletics or related activities without undue risk or injury.

___ Adapted: Student has a condition which might risk sustaining injury from participation in the regular Program or needs a special adapted program as indicated by the consulting physician. Re-examine each year.

___ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the Regular or adapted programs. These students should be re-examined for possible reclassification at the end of the exemption period.

Recommendations: _____

Your signature below indicates completion of physical exam

Date _____ Signed _____ M.D.

Examining Physician (Signature Required)

Clinic/Practice Name (please print) _____

Physician Address _____ Physician Phone # _____

RETURN TO SCHOOL HEALTH OFFICE