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|  | **2020 - 2021 Student**  **Physical Evaluation Form**  **for Primary through 5th grades** |

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2020 - 2021 Grade level: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**TO BE COMPLETED BY PHYSICIAN:**

(A) Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student require an EPIPEN? Yes\_\_\_\_ No\_\_\_\_

**All students diagnosed with severe allergies must have an allergy action plan completed**

(B) List any history of serious/chronic illness (INCLUDING ASTHMA), injury, surgeries or mental health issues.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the student have an inhaler? YES \_\_\_\_\_ NO \_\_\_\_\_

May the student self carry the inhaler? YES \_\_\_\_\_ NO \_\_\_\_\_

**All students diagnosed with asthma must have an asthma action plan completed**

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Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(C) Physical Exam (**must be completed in full) :**

Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_lbs BP: \_\_\_\_\_\_\_\_ Heart Rate: \_\_\_\_\_\_

Scoliosis: \_\_\_\_\_\_(Y/N) If present - Intervention: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Hearing: R \_\_\_\_\_ L \_\_\_\_\_ (pass/fail) Referral: \_\_\_\_\_\_\_ (Y/N)

\*\*\*Vision: R\_\_\_\_ L\_\_\_\_ OU\_\_\_\_ Glasses/Contacts: \_\_\_\_ (Y/N) Referral: \_\_\_(Y/N)

General appearance \_\_\_\_\_ Head/Neck \_\_\_\_\_ Eyes \_\_\_\_\_ Nose/Mouth \_\_\_\_\_

Teeth \_\_\_\_\_\_ Heart \_\_\_\_\_\_ Lungs \_\_\_\_\_\_ Skin \_\_\_\_\_\_ Abdomen \_\_\_\_\_\_

Musculoskeletal \_\_\_\_\_\_\_ Neurologic \_\_\_\_\_\_\_ GU \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_

Comments/Abnormal findings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(D) Current Medications: Reason for taking medication:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(E) Clearances:

\_\_\_\_\_ Student is cleared for **ALL** sports/gym without restrictions.

\_\_\_\_\_ Student is **NOT** cleared for sports until evaluation/ treatment of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Student is cleared for **LIMITED** participation.

Limits: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(F) Student may have the following over the counter drugs with parental consent:

Acetaminophen, Ibuprofen, Naproxen Sodium, Calcium Carbonate (Tums),

NaphconA (allergy relief eye drops), & throat/cough drops.

{Dosage age/weight appropriate}

Provider’s Initials: \_\_\_\_\_\_\_\_\_

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Student’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\* PLEASE attach immunization record to \*\*\*\*\***

**this completed form.**

History reviewed and student examined by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Physician’s / Provider’s Signature) (Date of Exam)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Physician’s / Provider’s Name) (Today’s date if different than exam date)

Physician’s / Provider’s Stamp or Address and Phone #

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