EVERY STUDENT **MUST** HAVE A CURRENT (WITHIN ONE YEAR) PHYSICAL EXAM TO ATTEND DOANE ACADEMY.

**\*\*\*** THIS FORM MUST BE RETURNED PRIOR TO THE START OF THE SCHOOL YEAR FOR

 NEW STUDENTS and RETURNING STUDENTS WITH PHYSICALS COMPLETED JUNE

 THROUGH AUGUST.

**\*\*\*** FOR RETURNING STUDENTS WITH PHYSICALS COMPLETED DURING THE SCHOOL

 YEAR, FORMS MUST BE RETURNED WITHIN ONE WEEK OF PHYSICIAN’S VISIT.

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

2018-2019 Grade level: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  |

**TO BE COMPLETED BY PHYSICIAN:**

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Does the student require an EPIPEN, an inhaler or any other medication? Yes\_\_\_\_ No\_\_\_\_

If yes, Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can student self carry? Yes\_\_\_ No \_\_\_

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

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

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

page 1 of 3

(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, Ibuprophen, Naproxen Sodium, Calcium Carbonate (Tums),

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

{Dosage age/weight appropriate}

 Provider’s Initials if approved: \_\_\_\_\_\_\_\_\_

 page 2 of 3

(G) Immunizations received this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\*\*\*\*\* 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 #

|  |
| --- |
|  |

04/2018 page 3 of 3