GREATER PORTLAND CHRISTIAN SCHOOL

# Student Physical Examination Form

***To be completed by Healthcare Provider for all New Students, Kindergarteners, and every other year for Gr. 6 - 12 Athletes***

Date of Physical Exam:_____

| Student Name | Sex | Age | Date of Birth | Grade |
|---|---|---|---|---|
| | | | | |

Height:_____ Weight_____ BP:_____ P: _____ R:_____ Last Tetanus (date)?_____

**Medications:** _____

**Allergies** (foods, insects, drugs, latex):_____

## ▶ HEALTH NEEDS IN SCHOOL

This student has the following problems, which may adversely affect his or her education experience (explain below):

☐ Cardiac ☐ Chronic Disease ☐ Physical Dysfunction ☐ Hearing ☐ Vision ☐ Speech/Language
☐ Behavioral/Social/Emotional/Psychiatric

Is this student on long-term medication ☐ Yes ☐ No Please specify: _____

Does this student have the knowledge and skill to carry and self-administer this medication? ☐ Yes ☐ No

☐ **Please attach an EMERGENCY ACTION PLAN for the following conditions:**

☐ Anaphylaxis (food/sting allergy) ☐ Asthma ☐ Diabetes ☐ Seizure ☐ Other: _____

Comments and recommendations (additional information about any of the above conditions/assessments): _____

_____

_____

## ▶ IMMUNIZATIONS: Up-to-date? ☐ Yes ☐ No ☐ *Please attach a complete Immunization record.*

☐ Medical Exemption: This student has not received immunizations for medical reasons (specify immunizations):

_____

☐ Permanent ☐ Temporary (Please specify plan for immunization)_____

_____

## ▶ HEALTH CARE PROVIDER'S REVIEW

I have reviewed the data above, reviewed the student's medical history and make the following recommendations for his/her participation in the school program/athletics/physical education:

☐ **CLEARED WITHOUT RESTRICTIONS:** This student may participate fully in the school program, including physical education, activities, sports, and co-curricular activities.

☐ **Cleared AFTER further evaluation or treatment** for_____

☐ **Cleared for LIMITED PARTICIPATION:** Reason(s) and explanation:_____

_____

☐ **NOT CLEARED FOR PARTICIPATION:** Reason(s) and explanation:_____

_____

_____ _____
Health Care Provider signature Date

_____ _____
Health Care Provider name (print) Name/Group Practice (print)