Student Physical Examination Form

To be completed by a 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)

Greater Portland Christian School, 1338 Broadway, South Portland, ME 04106
Voice (207) 808-8350 • Fax (207) 808-8592 • office@gpcs.net

2024.02.07