South Country
Central School District
Verne W. Critz Elementary School

Main Office #631-730-1675 Health Office #631-730-1690 Fax #631-286-2918

PHYSICAL EXAMINATION FORM

Name _____ Grade _____

Physician: Please answer all information completely.

Age: _____ Ht: _____ Wt: _____ BMI: _____ Blood Pressure: _____

Vision: R_____L_____ (Uncorrected) R_____L_____ (Corrected) Hearing: R_____L_____

Immunization Update Information: _____
Any History of: **Allergies** _____
Diabetes _____ **Asthma** _____
Cardiac Disease _____ Seizure Disorder _____
Recent injury or operations (within 1 yr) _____

H.E.E.N.T _____
_____
Lymph Nodes: _____
Thyroid: _____
Heart: _____
Lungs _____
Abdomen: _____

Scoliosis: _____
Musculoskel _____ Gait _____
Neurological: _____
Urogenital: _____ Tanner: ___
Skin: _____
Speech: _____
General condition: _____

REFERRALS/COMMENTS/FOLLOW-UP _____
APPROVED FOR PHYSICAL EDUCATION? YES _____ NO _____
LIMITATIONS: _____

DATE OF EXAM: _____
SIGNATURE AND STAMP OF PHYSICIAN: _____