

South Country School District
Physical Examination Form K-5
To Be Filled Out By Physician

Name _____ Grade _____

Physician: Please answer all information completely.

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

Vision: R ____ L ____ R ____ L ____ Hearing: R ____ L ____
(Uncorrected) (Corrected)

.....
Immunization Update Information _____

Any History of: Diabetes _____ Seizure disorder _____
Cardiac Disease _____ Asthma _____
Recent injury or operations (within 1 yr.) _____

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H.E.E.N.T. _____ Scoliosis: _____
Lymph Nodes: _____ Musculoskel: _____ Gait: _____
Thyroid: _____ Neurological: _____
Heart: _____ Urogenital: _____ Tanner: _____
Lungs: _____ Skin: _____
Abdomen: _____ Speech: _____
General Condition: _____

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Referrals/Comments/Follow-Up: _____
Approved for Physical Education? Yes _____ No _____

Limitations: _____

(Signature of Physician) _____
(Date of Exam)

(Stamp of Physician)

South Country Central School District
Health History and Examination Gr. K-5
To Be Filled Out By Parent

Name: _____ Birthdate: _____

Grade: _____ School: _____

1. Has your child ever had any of the following?(If YES, Circle and explain).

Pneumonia	Whooping Cough	Tonsilitis
Tuberculosis	German Measles	Frequent Colds
Rheumatic Fever	Asthma	Hearing Loss
Epilepsy	Diabetes	Vision Problems
Chicken Pox	Anemia or Sickle Cell	Heart Trouble
Measles	Mononucleosis	Skin Disorders
Mumps	Kidney Trouble	Hernias

Date of Illness: _____ Explanation: _____

2. Has your child ever had: chest pain, murmurs, irregular beats, shortness of breath, or been treated for any other “heart problems”?

No _____ Yes _____ Explanation: _____

3. Has your child ever had high blood pressure? No _____ Yes _____

4. Has your child ever had a fracture, serious injury, or illness requiring medical attention or surgery? If YES, list area and date. _____

5. Does your child have any persistent swelling in his/her joints? Yes _____ No _____

6. Does your child wear glasses, contact lenses, hearing aid or other prosthesis? _____

7. Does your child have a hearing loss in either ear? If Yes, which ear? _____

8. Has your child ever had any serious eye injury or vision problem? Yes ___ No ___

9. Is your child allergic to anything? If Yes, please explain. _____

10. Is your child taking any medication? If Yes, Please explain. _____

11. Does your child have any medical condition that we should know about?

Explanation _____
