Student Physical Hopatcong School District

Name:	Date of Physical Exam:
Gender: Male Female	DOB: Age:

PHYSICAL EXAM	NORMAL	IF ABNORMAL - COMMENTS
Skin and lymph nodes		
Eyes		
Ears		
Nose		
Throat		
Teeth and Gums		
Glands – cervical thyroid other		
Heart/Cardio		
Lungs/Respiratory		
Abdomen/GI		
Hernia		
Kidneys/Bladder/GU		
Neurologic/Developmental/Speech		
Orthopedic		

MEDICAL CONDITIONS

Chronic Medical Conditions	[] none	comments
Surgeries	[] none	comments
Medications/Treatments	[] none	comments
Allergies-Food or Medication	[] none [] care plan attached	comments
Emergency Plans (asthma, diabetic, seizures, Epinephrine)	[] none [] care plan attached	comments
Special diet/Vitamin & Mineral supplements	[] none	comments
Behavior Issues/Mental Heath Diagnosis	[] none	comments

PREVENTIVE HEALTH SCREENINGS

Type	Date Performed	Results	Type	Date Performed	Results
Hearing			Scoliosis		
Vision		Left eye	Right eye	Both eyes	
Height:		Weight:		B/P:	

TB (mm of induration)_____ date performed_____

Are there any other restrictions to child's activities or physical limitations?_____

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all school activities, including physical education and competitive contact sports, unless noted above.***

Health Care Provider Stamp

Name of Health Care Provider (print)

Signature/Date Form Signed