

FAMILY PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

Name _____ Birth Date _____

School _____

Grade _____

PHYSICAL EXAMINATION *(To be completed by licensed health care provider. Other forms may be used at the discretion of the school nurse)*

DATE: _____ Height _____ Weight _____

Remarks or special instructions: Previous Diseases and Operations: _____

Is this child capable of carrying a full program of school work including gymnastics and athletics? Yes _____ No _____

Must the school program be modified to meet the needs of this child? Yes ___ No ___

By restriction of use of stairs: Yes ___ No ___

By special seating accommodations? Yes ___ No ___

Other (specify) Yes ___ No ___

Completed immunizations: Yes ___ No ___ If no, please explain: _____

Date of examination

Examining Health Care Provider

Approved: November 2020