NOTE: This form is being provided per State Law. Another form may be used so long as ALL information on this form is included.

DOVER MIDDLE SCHOOL ◊ PHYSICAL EXAMINATION FORM
NURSE: 516-7287 FAX: 516-8462

PATIENT NAME_____Date of Birth_____Date of Exam_____

General Appearance and Development ☐ HEALTHY ☐ FAIR ☐ POOR GENDER: ☐ MALE ☐ FEMALE

MEDICATIONS_____ ALLERGIES_____

SPECIAL CONCERNS/INSTRUCTIONS_____

PAST MEDICAL HISTORY/SURGERIES_____

VITAL SIGNS: BLOOD PRESSURE _____/_____ TEMP_____ PULSE_____MIN RESPIRATIONS_____/MIN

HEIGHT:_____ WEIGHT_____ BMI_____

VISION: ☐ W/ CORRECTION ☐ W/O CORRECTION DISTANCE LEFT 20/_____ RIGHT 20/_____

HEARING: WNL ☐ YES ☐ NO COMMENTS:_____

EXAMINATION: TANNER: I II III IV V SCOLIOSIS: ☐ NEGATIVE ☐ POSITIVE

COMMENTS_____

CATERGORY	N	A	COMMENTS	CATERGORY	N	A	COMMENTS
EYES/EARS/NOSE				BACK/SPINE			
MOUTH/THROAT				MUSCULAR/SKELETAL			
HEAD/NECK				SKIN			
CHEST/LUNGS				LYMP/VASCULAR			
HEART				NEUROLOGICAL			
ABDOMEN				ENDOCRINE			

Additional comments:_____

_____

Physical Activity Restrictions: (none ☐) _____

PLEASE ATTACH A COPY OF PATIENT'S CURRENT IMMUNIZATION RECORD

_____ _____ _____

Physician's Printed Name Physician's Signature date

Physician's Contact Info: telephone number_____fax number_____

REVISED 3/2017