Health Services Physical Form

Name: **DOB:**

PHYSICIAN COMPLETE THIS SECTION:

B/P: **HR:** **HT:** **WT:**

Physical Exam:	WNL	Needs Followup	Comments
Skin, Scalp			
Eyes			
Ears			
Nose			
Mouth,Throat			
Teeth, Gums			
Heart, Lungs			
Abdomen			
Bones, Joints			

Speech Difficulties:
Emotional/Behavioral Problems:

Comments:

Recommendation for Physical Education: Full Program Restricted Modified

Comments:

History of Chronic Diseases/Allergies:

Immunization Information:
DTaP Booster IPV Booster MMR Booster VARIVAX
HX of Varicella

Examined By: **Date:**

PARENT: Please complete the following release of information:

I give permission for ___________________________ to release information to school nurse.
(physician)

Signature: