



LINN-MAR COMMUNITY SCHOOLS

STUDENT PHYSICAL EXAM FORM

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____ Home Phone: _____

School: _____ Grade: _____ Sex: M _____ F _____

HGB/HCT	BP	Lead	Height	Weight	Visual Acuity	Urinalysis	Hearing Acuity
		Date done:			R eye:	Sp Gr:	R ear:
		Results:			L eye:	Sugar	L ear:

GENERAL EXAM Check if Normal/Abnormal

	Normal	Abnormal	Explain
Teeth			
Throat			
Heart			
Lungs			
Abdomen			

	Normal	Abnormal	Explain
Neuro			
Skin			
Gait			
Back			

PHYSICIAN RECOMMENDATIONS	NO	YES	EXPLAIN
1. Is there any significant health history? Chronic illness, surgeries, injuries?			
2. Is this student subject to any condition that may result in a classroom emergency or limit participation during the school day – Diabetes, asthma, allergies, seizures, cardiac?			
3. Student immunizations are up to date?			
4. Immunizations given today?			
5. Updated TDAP for 7 th Grade?			
6. Student can participate in all school activities?			

Additional Comments: _____

I have interviewed and examined this student on _____ (date of exam).

Print Physician's Name: _____ Phone: _____

Print Physician's Address: _____

Physician's Signature: _____ Date: _____