ROCKWOOD SCHOOL DISTRICT PHYSICAL EXAMINATION FORM
FOR
KINDERGARTEN • NEW STUDENTS • GRADE 6 • HIGH SCHOOL SPORTS

PLEASE RETURN COMPLETED HEALTH EXAMINATION FORM TO THE SCHOOL NURSE.
ANY QUESTIONS REGARDING COMPLETION OF THIS FORM MAY BE DIRECTED TO THE SCHOOL NURSE.

STUDENT NAME: _____________________________ DATE OF BIRTH: _______ _______ GRADE: _______

TO BE COMPLETED BY PHYSICIAN
DATE OF EXAM: _____________________________

IMMUNIZATIONS (give month/day/year or attach record)

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<tr>
<th>Vaccine</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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<td>DTP/DTaP</td>
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<td>Meningococcal</td>
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<td>Other</td>
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PHYSICAL

Height: _____ Weight: _____ B/P: _____ / _____ Pulse: _____

Eyes: R – 20/ _____, L – 20/ _____ Hearing: ________________

Scoliosis screening ________________

Review of Systems: ________________

Note any problems: ________________

ORTHOPEDIC EXAM (for PE/sports participation)

Back/Neck/Shoulders/Extremities: WNL ________________

If not, please explain: ________________

Recommendation for PE/Sports: Full / Limited / None

Clearance withheld until: ________________

If limitations, please explain: ________________

HISTORY

Asthma: No_____ Yes_____

ADHD: No_____ Yes_____

Chronic Condition/Major Surgeries: (list, give date) ________________

Allergies (list): ________________

Medications (list): ________________

ORTHOPEDIC HISTORY (for sports participation)

Previous Injury Date, Explain: ________________

Special Seating Recommendations: ________________

Medical Treatment Needed at School: ________________

Other Health Recommendations: ________________

FOR HIGH SCHOOL SPORTS PARTICIPATION ONLY - Parent’s or Guardian’s permission:

I hereby give my consent for the student to represent his/her school in interscholastic activities, except those stated on the form by the examiner; I also give my consent for him/her to accompany the team as a member of its out-of-town trips and will not hold the school responsible in case of accident or injury. I also give consent and authorize the school to obtain, through a physician of its choice, such medical care as is necessary for the welfare of the student, if he/she is injured in the course of school activities.

Signature of Parent _____________________________ Date __________________

FORM P2880 rev.12/09