***Form #3***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | ***RIVER VALLEY SCHOOL DISTRICT*** | | | | | | | |  |  |
|  |  |  |  |  |  | **Physical Examination Form** | | | | | |  |  |
| Name | | |  |  |  |  |  |  |  | Birthdate | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Parents | | |  |  |  |  | Address | | | | |  |  |
| Height | | |  | Weight | |  |  | Vision | | | | Hearing | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Significant illnesses, accidents, operations, congenital defects, family history, etc.

For any pre-existing conditions (i.e. diabetes, epilepsy, asthma, etc.), please indicate medication and dosage child may be taking:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Will he/she need medication at school? | | | | | | | | | | Comments: | | | | |  |  |  |  |  |
|  | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| EXAM: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Skin | | | | | EENT | | | | |  |  | Glands | | |  |  |  |  |  |
|  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lungs | | | | | Abdomen | | | | |  |  | Nervous System | | |  |  |  |  |  |
|  | |  |  |  |  | | |  |  |  |  |  |  | |  |  |  |  |  |
| Heart: Rate | | | | | Blood Pressure | | | | |  |  | Size | | | Murmurs | | | |  |
| Hernia | |  |  | |  |  |  |  |  |  |  |  |  |  | Genitalia | | |  |  |
| Bone or Joint Irreg. | | | | |  |  |  |  |  |  |  |  |  |  | Posture | | | |  |
|  | | | |  |  |  |  |  |  |  |  |  | | |  |  |  | |  |
| Scoliosis Screening | | | | |  |  |  |  |  |  |  | Emotional Problems? | | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Suspected Learning Disability?

Any Classroom Restrictions or Recommendations?

Any Restrictions in Physical Education Classes?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of Exam |  | Signature of Examining Physician | | |
|  |  | Clinic & Address |  |  |

Immunizations given at this clinic: