

YEARLY PHYSICAL

Today's Date

SECTION III - PERSONAL

Child's Address (Number & Street, City, State, Zip Code)		
Parent's or Guardian's Name (Last, First, Middle)	Telephone (Home)	Telephone (Work)
Parent's Address (Number & Street, City, State, Zip Code)		

SECTION IV - TESTS AND MEASUREMENTS

TEST TYPE	NO	YES	DATE TESTED	WEIGHT: LBS.			HEIGHT: Ft. In.		NORMAL	UNDER CARE	REFERRED
				<input type="checkbox"/> Visual Acuity	<input type="checkbox"/> Ocular Muscle	<input type="checkbox"/> Other					
VISION	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEARING	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Audiometer	<input type="checkbox"/> Other				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEMOGLOBIN/HEMATOCRIT	<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
URINALYSIS	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Sugar	<input type="checkbox"/> Albumin	<input type="checkbox"/> Microscopic			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>		Reading					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULIN	<input type="checkbox"/>	<input type="checkbox"/>		Type	Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative		mm.				
OTHER (Specify) ▶											
OTHER (Specify) ▶											
Essential findings deviating from normal and/or recommendations											

SECTION V - RECOMMENDATIONS

DATE	EXAM TYPE AND RESULTS	CLINIC'S NAME AND EXAMINER'S NAME
	Type _____ Results _____	Clinic _____ Examiner _____
	Type _____ Results _____	Clinic _____ Examiner _____
	Type _____ Results _____	Clinic _____ Examiner _____
	Type _____ Results _____	Clinic _____ Examiner _____
	Type _____ Results _____	Clinic _____ Examiner _____

Is there any defect of vision, hearing or other condition for which the school could help by seating or other action? <input type="checkbox"/> NO <input type="checkbox"/> YES ▶ If Yes, explain below.	Should the student's activity be restricted because of any physical defects or illness? <input type="checkbox"/> NO <input type="checkbox"/> YES ▶ If Yes, explain below.
Explanation:	Restriction: <input type="checkbox"/> Classroom <input type="checkbox"/> Gymnasium <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Playground <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Camp <input type="checkbox"/> Other (Specify) _____
	Explain Degree of Restriction:
EXAMINER'S SIGNATURE _____ <div style="text-align: right;">DATE _____</div>	
Examiner's Name (Print or Type) _____	Degree or License _____ Telephone Number _____
Address (Street Number and Name) _____	City _____ State _____ Zip Code _____