Wells - Ogunquit C.S.D.

PHYSICAL EXAM FORM Grade _____

Student's Name _____ Male _____ Female _____
Home Address _____ Date of Birth _____
Parent's Name _____ Telephone _____

MEDICAL HISTORY
(To Be Completed By Parent)

Asthma? _____ Epilepsy? _____ Chronic Ear Infections? ____
Allergies? _____ Diabetes? _____ Urinary Tract Infections? ___

Please describe any above mentioned or other relevant health history. _____

_____

_____

Currently receiving medication? _____ For What? _____

Name of medication _____

Vision Problem? _____ Wears glasses or contacts? _____

Hearing Problem? _____ Please describe _____

Removable dentures, braces, etc.? _____

Previous major illnesses (with dates) _____

Previous significant injuries (with dates) _____

_____

Date of most recent booster (Tetanus) _____ (Polio) _____

Is there any reason why this student should not participate in interscholastic athletics?

Please check one:

_____ Our Physician will perform the physical.

_____ I give permission for the above-mentioned student to obtain a physical at school.
(Not relevant for Kindergarten physicals.)

_____ _____
Date Parent's or Guardian's Signature

(OVER)

NAME_____

MEDICAL EXAMINATION

To Be Completed By Physician

General Appearance_____ Height_____

Skin_____ Weight_____

Eyes_____ Blood Pressure_____

Ears_____ Pulse_____

Nose_____

Mouth/Throat_____ Urine:

Lymph Nodes_____ Protein_____

Heart_____ Glucose_____

Lungs_____ Other_____

Abdomen_____

Spleen/Liver_____ Blood Test: (optional)

Hernia _____ _____

Posture (Scoliosis)_____

Genitalia/Menstruation_____ Hearing: R_____L_____

Feet_____ Vision: R_____L_____

Recommendations for Physical Activity:

_____ Full Program (including interscholastic and contact)

_____ Restricted Program (please explain)

Other Remarks or Recommendations:_____

_____

_____

_____ _____

Date of Exam Physician's Signature

_____ _____

Telephone Number Printed Name