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_____

Skin _____

Eyes _____

Ears _____

Nose _____

Mouth/Throat_____

Lymph Nodes _____

Heart _____

Lungs _____

Abdomen_____

Spleen/Liver_____

Hernia _____

Posture (Scoliosis)_____

Genitalia/Menstruation_____

Feet_____

Height _____

Weight _____

Blood Pressure _____

Pulse_____

Urine:

Protein _____

Glucose_____

Other _____

Blood Test: (optional)

_____

Hearing: R_____ L _____

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: _____