

BRUNSWICK CENTRAL SCHOOLS

BRITTONKILL

SCHOOL PHYSICAL EXAM FORM

Name: _____ Date of Birth: _____

School: _____ Gender: M F Grade: _____

IMMUNIZATIONS / HEALTH HISTORY

- Immunization record attached Sickle Cell Screen: Positive Negative Not done Date: _____
 No immunizations given today PPD: Positive Negative Not done Date: _____
 Immunizations given since last Health Appraisal: Elevated Lead: Yes No Not done Date: _____
Dental Referral: Yes No Not done Date: _____

Significant Medical/Surgical History: See attached _____

Specify current diseases: Asthma Diabetes: Type 1 Type 2 Hyperlipidemia Hypertension
 Other: _____

Allergies: History of Life Threatening Reactions Insect: _____
 Seasonal Food: _____ Other: _____
 Medication: _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

		Referral	
Body Mass Index: _____	Vision - without glasses/contact lenses	R	L
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L
<input type="checkbox"/> less than 5 th <input type="checkbox"/> 5 th through 49 th <input type="checkbox"/> 50 th through 84 th	Vision - Near Point	R	L
<input type="checkbox"/> 85 th through 94 th <input type="checkbox"/> 95 th through 98 th <input type="checkbox"/> 99 th and higher	Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	R	L

EXAM ENTIRELY NORMAL

Tanner: I. II. III. IV. V.

Scoliosis: Negative Positive: _____

Specify any abnormality (use reverse of form if needed): _____

MEDICATIONS

Medications (list all): None Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

Student may self carry and self administer medication Yes No

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Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

Over the counter medications that can be administered at school:

- Tylenol/Jr. Tylenol
- Ibuprofen (2nd grade and up)
- Antibiotic ointment
- Anbusol/Orajel
- Benadryl (for moderate to severe swelling caused by insect bites/bee stings)

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

- Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:

___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.

___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

- Specify medical accommodations needed for school: _____ None

- Known or suspected disability: _____ Please monitor

- Restrictions: _____ Please monitor

- Protective equipment required: Athletic Cup Sport goggles/impact resistant eyewear

- Other: _____

(Stamp below)

Provider's Signature: _____

Phone: _____

Provider's Name/Address: _____

Fax: _____

Parent Signature: _____

Date: _____