Our Savior's Lutheran School

Physical Examination Form

To be completed by Physician, Physician Assistant or Nurse Clinician.

STUDENT PHYSICAL EXAMINATION RECORD:

Child's Name_____ Birthdate_____ Age/Grade _____

Weight _____ lbs.
BP _____/_____
Distance Visual Acuity: R 20/ ____ L 20/ ____

Height _____ inches
Pulse_____
Hearing: R _____ L _____

	Normal	Abnormal	Comments
Skin/Scalp			
Mouth			
Teeth			
Ears, Nose, Throat			
Neck			
Heart			
Lungs			
Abdomen			
Orthopedic			
Neurologic			
Other			

Are there any restrictions for this student at school? ☐ Yes ☐ No
If yes, please explain:

Were there any immunizations given at this appointment? ☐ Yes ☐ No
If yes, please list:

Are there any additional tests or evaluations recommended for this student? ☐ Yes ☐ No
If yes, please list and/or explain:

Are there any specific recommendations for this student at school? ☐ Yes ☐ No
If yes, please list and/or explain:

EXAMINING HEALTH PROFESSIONAL CONTACT INFORMATION:

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Clinic:_____

Examiner's Signature _____ Exam Date_____

PLEASE RETURN PHYSICAL EXAMINATION FORM TO SCHOOL OFFICE UPON COMPLETION