

**El estudiante Examen Fisico
Eduque el Distrito de Fort Atkinson**

El Nombre del estudiante: _____ La escuela: _____ El grado _____

Height: _____ Weight: _____ Blood Pressure: _____

Visual Acuity: R _____ L _____ With Correction: Yes No

Chronic Health Concerns: _____

Current Medication(s): _____

Will medication be given at school? Yes No

If yes, please complete the SDFA Administering Medication to Students form.

Does student have any allergies? _____

	NORMAL	ABNORMAL	COMMENTS
EYES			
EARS			
NOSE			
THROAT			
TEETH			
GLANDS			
THYROID			
SCALP & SKIN			
HEART			
LUNGS			
ABDOMEN			
POSTURE			
ORTHOPEDIC & FEET			
GROSS MOTOR			
FINE MOTOR			
NERVOUS SYSTEM			
NUTRITION			

Immunizations given: _____

Physician Referral/Recommendation: _____

Activity Restriction (s): _____

Physician and Clinic name and address

Physician Signature

Date