Student Physical Examination
School District of Fort Atkinson

Student Name:_________________________ School:________________________ Grade

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 our "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