

SARATOGA SPRINGS CITY SCHOOL DISTRICT

Saratoga Springs, New York 12866

For new entrants, students in grade K, 2, 4, 7, 10

REPORT OF PHYSICAL EXAMINATION BY FAMILY PHYSICIAN

NAME: _____

Gender DATE OF BIRTH: _____
 M F

ADDRESS: _____

SCHOOL: _____

GRADE: _____

IMMUNIZATIONS AND TESTS

OPV/IPV: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___
DTap: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___
dT: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
HIB: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___
Varicella: 1. ___/___/___ 2. ___/___/___
MMR: 1. ___/___/___ 2. ___/___/___
HBV: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
Tdap Booster 1. ___/___/___
PVC: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___
Other: _____ /___/___

EXAM ENTIRELY NORMAL _____ Significant Medical/Surgical History: see attached _____
FOR MEDICAL EXEMPTION: Attach documentation

Please indicate any other health information that would be of importance to the school by completing the reverse side of this form.

Height: _____ Weight: _____ Blood Pressure _____

Body Mass Index: _____

Weight Status Category (BMI Percentile)

- Less than 5th 5th through 49th 50th through 84th
- 85th through 94th 95th through 98th 99th and higher

MEDICATIONS: (list all)

Name _____ Dosage/Time _____

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I assess that student to be self directed for the school setting. _____

HEART: _____

EYES: _____

EARS: _____

NOSE: _____

TONSILS: _____

TEETH: _____

LYMPH NODES: _____

Allergies:

- Life Threatening: Food: Insect:
- Seasonal: Medication: Other: _____
- Asthma:
- Diabetes: Type 1: Type 2:
- Hypertension:
- TANNER: I. II. III. IV. V.

SCOLIOSIS: _____ Negative: Positive:

DENTAL RECORD No Yes Date _____

ABDOMEN: _____

GENITO-URINARY (Tanner Scale): _____

THYROID: _____

ORTHOPEDIC (Structural): _____

POSTURE: _____

FEET: _____

NERVOUS SYSTEM: _____

To enable the school to better know the physical history of this child and to meet his / her individual needs, we ask that you complete the following:

Has this child ever had any significant disease? Yes: _____ No: _____

If Yes, what? _____ Date: _____

Has this child ever had surgery? Yes: _____ No: _____

If Yes, what type of surgery? _____ Date: _____

Has this child been hospitalized for any reason? Yes: _____ No: _____

If Yes, what reason? _____ Date: _____

Where? _____

Does this child have any physical condition the school should know about? Yes: _____ No: _____

If Yes, what? _____ Date: _____

Does this child have any special needs because of this condition? _____

Is this child able to participate in regular physical education? Yes: _____ No: _____

Please list any restrictions from the normal physical education program or any differences in the school program for this child.

Please describe in more detail any positive findings. _____

*** ABOVE INFORMATION MUST BE CERTIFIED BY SIGNATURE OF A DULY LICENSED PHYSICIAN ***

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, weight train, crew, dance, track, run, walk, rope jump

PHYSICIAN'S SIGNATURE _____ Date of Exam _____

Physician's Name (Please Print) _____

Address _____

_____ Phone No. _____