SAINT MARGARET SCHOOL

PHYSICIAN'S PHYSICAL FORM

To be completed **ONLY** by Physician/Nurse Practitioner

Student's Name (Last, First, MI)		Birthdate (Mo. DayYr.)	**Sex (M/F)**	**Grade**

1. **Does the child have a diagnosed medical condition?**
   No___ Yes____
   ____

2. **Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school: (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE. Additionally, please "work with your school nurse to develop an emergency plan".**
   No___ Yes____
   ____

3. **Are there any abnormal findings on evaluation for concern?**

Evaluation Findings/CONCERNS

Physical Exam	**WNL**	**ABNL**	**Area of Concern**	**Health Area of Concern**	**YES**	**NO**
Head				Attention Deficit/Hyperactivity		
Eyes				Behavior/Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure/Elevated Lead		
GI				Learning Disabilities/Problems		
GU				Mobility		
Musculosketal/orthopedic				Nutrition		
Neurological				Physical Illness/Impairment		
Skin				Psychosocial		
Endocrine				Speech/Language		
Psychosocial				Vision		
				Other		

REMARKS: (Please explain any abnormal findings.)

4. RECORD OF IMMUNIZATIONS-DHMH 896 is required to be completed by a health care provider **or** a computer generated immunization record must be provided.

5. Is the child on medication? If yes, indicate medication and diagnosis.
   No___ Yes____
   (A medication administration form must be completed for medication administration in school).

6. Should there be any restriction of physical activity in school? If yes,, specify nature and duration of restriction.
   No___ Yes____

7. Screenings	Results	Date Taken
Tuberculin Test		
Scoliosis Screening		
Blood Pressure		
Height		
Weight		
BMI %tile		
Lead Test	Optional	

(Child's Name)____ has had a complete physical examination and has:
**no evident problem that may affect learning or full school participation **problems noted above

Additional Comments:

Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse Practitioner Signature	**Date:**

2011-05-26