

PHYSICAL FORM
BERNE-KNOX-WESTERLO CENTRAL SCHOOL
To parents of students entering grades K,2, 4, 7 & 10

Front to be completed by parent, and reverse of the form is to be completed by physician.

Under an amendment to section 903 of the state education law a Physician's Health Certificate must be furnished by children entering school for the first time and all children entering grades 2,4,7 and 10. For this reason, we are requesting your assistance in providing for this physical examination of your child by your family physician.

NAME _____ SEX _____ GRADE _____ DATE _____

PARENT PLEASE ANSWER ALL QUESTIONS!

1. Has had:

- | | | |
|--|-----------|----------|
| a. Rheumatic fever or scarlet fever | YES _____ | NO _____ |
| b. Seizure or convulsive disorder | YES _____ | NO _____ |
| c. Anemia (including sickle cell anemia) | YES _____ | NO _____ |
| d. Mononucleosis or hepatitis | YES _____ | NO _____ |
| e. Asthma | YES _____ | NO _____ |
| f. Diabetes | YES _____ | NO _____ |
| g. High Blood pressure | YES _____ | NO _____ |
| h. Kidney disease | YES _____ | NO _____ |
| I. Retinal detachment or eye disorder | YES _____ | NO _____ |
| j. Absence of a paired organ | YES _____ | NO _____ |
| k. Concussion (if yes, how many times ___) | YES _____ | NO _____ |
| l. Thyroid disease | YES _____ | NO _____ |
| m. Gastrointestinal disease | YES _____ | NO _____ |

2. Any known allergies?

YES _____ NO _____

Medication _____

Other type _____

3. Take any medication now? Name _____

YES _____ NO _____

4. Under care of physician now? Name _____

YES _____ NO _____

5. Had an illness lasting more than a week?

YES _____ NO _____

6. Have been in a hospital?
(Except for tonsillectomy)

YES _____ NO _____

7. Has had surgical operation? Year & Surgery

YES _____ NO _____

8. Wears glasses or contact lenses?

YES _____ NO _____

9. Has emotional problems requiring medical care?

YES _____ NO _____

10. Has had low back pain, injury to bone, tendons, joints?

YES _____ NO _____

Explain _____

11. Date of last tetanus injection _____ Date of last dental exam _____

PARENT SIGNATURE _____ DATE _____

(OVER)

(revised 1/06)

NAME _____ **D.O.B.** _____

Height _____ Normal Pulse _____

Weight _____ Pulse after exercise _____ Gr. 7-12

Blood Pressure _____ Pulse after 2 min rest _____ Gr. 7-12

Vision: R _____ L _____ Nutrition _____

Ears: R _____ L _____

Teeth _____ Gums _____ Tonsils _____

Glands: Cervical _____ Thyroid _____ Other(specify) _____

Heart _____ Lungs _____ Asthma _____

Orthopedic: Structural defect _____ Scoliosis _____

Feet _____

Skin _____ Hernia _____

Nervous system (specify if epilepsy) _____

Classification for physical education _____
_____ Restricted

_____ Restricted until cleared by regular physician

_____ Unrestricted

Void if student is absent for five or more consecutive days.

IMMUNIZATIONS:

MMR _____ HIB _____

DTP _____ DT _____ DT _____

IPV _____

HepB _____

VARIVAX _____

PHYSICIAN SIGNATURE _____ **DATE** _____

PRINT PHYSICIAN NAME _____