WEST GENESEE CENTRAL SCHOOL DISTRICT
300 Sanderson Drive, Camillus, NY 13031

Physical Examination Form

Student____Date of Birth________ Grade________

Please complete ALL sections

Allergies:
____
____
____

Ht ________
Wt ________
BP________
BMI_______
B.M.I. %: _______

Scoliosis: □ neg □ pos

Eyes
Ears
Nose
Mouth
Genito-Urinary
GI
Heart
Lungs
Nervous System
Nutrition
Lymph Nodes
Muscular/Skeletal
Skin
Thyroid

Tanner: I II III IV V

□ **Exam Completely Normal**

NYS Requires the following grades to have Vision and Hearing Screening

Hearing-K,1,3,5,7 & 10

□ Pass 20 dc sc both ears

R_______L________

Vision-K,1,2,3,5,7 & 10

Without Correction:
R 20/ ______ L 20/______

With Correction:
R 20/_______ L 20/______

Near Point: R_____L______

Physical Activity in School:

□ Full physical activity including sports

□ Modified activity: ____

□ Cleared for interscholastic athletics by private physician, (Name)____________________________

□ Cleared for interscholastic sports by school physician

Medications for use at school/sports: □ None
□ ______________________________ Dosage____________
□ ______________________________ Dosage____________
□ ______________________________ Dosage____________

Date of Physical____________Examiner's Signature________________________________(MD, PA or NP)

Print or Stamp Name____Phone Number______________

Please attach a complete and up-to–date list of all immunizations

Dear Parents,

The New York State Department of Education requires health examinations and requests dental examinations are given to students upon entry into schools and upon entering grades K, 2, 4, 7 and 10. It is suggested that these be done by the family physician/dentist, as they are the ones that know the students' health history the best. They are better able to judge any changes in the child's state of health, and they can discuss any recommendations directly with the parents at the time of the exam. These exams are more detailed than school exams and any necessary immunizations or medications can be administered. These exams should be done up to one year prior to the first day of school.

We encourage continuance of annual examinations by your family physician and dentist.

Please complete the history below and return this form to the school health office within 30 days of entry. After this date, we will proceed with a health appraisal by the school doctor of all students who do not return a completed health form (on back). If your child has a scheduled appointment for later in the year, please contact us with the confirmed scheduled physical date.

____
School Nurse

Health Concerns/Health History: **Student:** __________________________

Check here if there are No known health problems

ALLERGIES __________________
□ Diagnosed by physician
□ Life threatening
□ Epi pen required
□ Health plan in place: Y or N
□ Needs medication in school
____

SEIZURE PROBLEMS
□ Grand Mal
□ Absence (petit mal)
□ Complex
□ Other: ________________
□ Plan needed? Y or N
Medication taken/needed:
____

HEART PROBLEMS
□ Type: __________________________
□ Plan needed? Y or N

BREATHING/RESPIRATORY PROBLEMS
□ Asthma
□ Exercise-induced asthma/Inhaler at School? Y or N

DIABETES
□ Type I (takes insulin)*
□ Type II (diet/medication control)
*Note: School plan is required

SOCIAL/EMOTIONAL SCREEN
□ Does student have sadness?
□ Does student have a history of depression?

ANY OTHER PHYSICAL OR MENTAL HEALTH PROBLEMS?
If so, please list: ____
____
____