Crescent School

Home of Future Leaders "Top Education in an Islamic Environment"

PHYSICAL EXAMINATION

STUDENT ______________________ **BIRTH DATE** ______________ **DATE OF EXAM** ____________

PHYSICAL EXAMINATION: Please return this form to the Health Office when your child enters in September. As required by law, new entrants to a school district and all children in grades Pre-K – 12 will be examined by the school physician if no report is received.
*** An annual physical examination is required for participation in interscholastic sports.**

1. BP ______________ Pulse ______________
2. Height ______________ Weight ______________
   Body Mass Index ______________
   Weight Status Category (BMI Percentile)-
   less than 5th 5th – 49th 50th – 84th
   85th – 94th 95th – 98th 99th and higher
3. Urinalysis ______________
4. Heart ______________
5. Breasts ______________
6. Lungs ______________
7. Eyes R ______________ L ______________
   With Glasses R ______________ L ______________
8. Visual Diagnosis ______________
9. Ears: Otoscopic ______________
   Audiometric ______________
   P.E. tubes Yes ______________ No ______________
10. Speech ______________
11. Nose ______________
12. Throat ______________
13. Tonsils ______________
14. Teeth and gums ______________
15. Skin ______________
16. Glands (cervical, thyroid, other) ______________
17. Nervous System ______________
18. Hernia ______________
19. Genitourinary ______________
20. Tanner I. II. III. IV. V.
21. Orthopedic: Scoliosis- Positive ____ Negative ____
    Posture ______________ Feet ______________
    Structural defects ______________
22. Abdomen ______________

SURGERIES: ______________________________

SIGNIFICANT ILLNESSES / INJURIES: ______________________________

ALLERGIES: ______________________________

ALL CHILDREN MUST TAKE PHYSICAL EDUCATION OR A MODIFIED PHYSICAL EDUCATION PROGRAM.

Full Activity ______________ Restriction ______________ Recommendation ______________

CURRENT MEDICATIONS (*Please List all medications and dosages*): ______________________________

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IMMUNIZATIONS (*Please fill in or attach record of immunization*)
* Please make sure your child has the correct number of age appropriate doses.

DTap/DTP/Tdap ______________

Tdap Booster ______________

Polio (OPV or IPV) ______________

MCV ______________

PCV ______________

MMR ______________

Varicella ______________

HIB ______________

HepB ______________

Other ______________

PROCEDURE /TESTS

TB Screening ______________

Chest X-ray ______________

Lead Screening ______________

Sickle Cell Test ______________

______________________________ ______________ ______________________________
Signature of Examining Physician Date Print Name

Physician's Address & Phone #:
(PLEASE STAMP)