KIRKWOOD
SCHOOL DISTRICT

Physical Examination

School: _____ **Grade**: _____ **Gender**: _____

Name: _____ **DOB**: _____ **Age**: ____

Address: _____ **Phone**: _____

City: _____ **State**: _____ **Zip**: _____

Physical Findings

Date of Exam:	**Height:**	**Weight:**
BP:	**Pulse:**	**Skin:**
Scalp:	**Teeth:**	**Gums:**
Nutrition:	**Eyes:**	**Ears:**
Nose:	**Throat:**	**Lymph:**
Lungs	**Heart:**	**Abdomen:**
Ortho:	**Reflexes:**	**Genitalia:**
Scoliosis:		

LIFE THREATENING ALLERGIES AND OTHER SIGNIFICANT HEALTH CONCERNS:

_____

_____

IMMUNIZATIONS: ***Please attach immunization record.***

Can pupil carry a full program of schoolwork? □ No □ Yes

Should physical activity be restricted? □ No □ Yes *(If yes, please explain below.)*

_____

_____

Is this child on daily medication? □ No □ Yes (*If yes, complete section below.)*

Medication: _____ Dosage: _____ Schedule: _____

Medication: _____ Dosage: _____ Schedule: _____

Medication: _____ Dosage: _____ Schedule: _____

Physician: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Physician Signature: _____ **Date**: _____

Revised 12/17/2015