**STUDENT PHYSICAL EXAMINATION FORM**

**First Presbyterian Preschool and Get Set Preschool**

STUDENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN

DATE OF EXAMINATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENERAL APPEARANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TEMPERATURE: \_\_\_\_\_\_\_\_\_ PULSE: \_\_\_\_\_\_\_\_ RESPIRATION: \_\_\_\_\_\_\_\_ B/P: \_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| System | Normal | Abnormal | Comments if abnormal |
| Skin |  |  |  |
| Eyes |  |  |  |
| Ears |  |  |  |
| Nose |  |  |  |
| Throat |  |  |  |
| Cardiovascular |  |  |  |
| Respiratory |  |  |  |
| Musculoskeletal |  |  |  |

SUMMARY OF FINDINGS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I herby certify that I have examined the above patient and that the above is a complete and accurate record of my examination.

I hereby state that this student is in good physical health and can perform the essential functions in preschool.

PRINT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.D / D.O

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL FACILITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_ \_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_