Private Physician Physical Form

This form is used for student in Grades K, 4, 8, and 10 and for new students entering the Palmyra School District.

Palmyra Public Schools
Palmyra, N.J. 08065

PART I - PHYSICAL EXAMINATION (This Page is to be completed by examining PHYSICIAN)
PART II - MEDICAL HISTORY (Next Page is to be completed by PARENT/GUARDIAN)

Name ____________ Exam Date ____________ Age ________ Date of Birth ____________

Address ____________ Day Phone ____________ Evening Phone ____________

Height ____________ Weight ____________ Sex ____________ Grade ____________

BP ____________ Pulse Rate ____________ Rhythm ____________

Vision: Corrected (L) ____________ (R) ____________ (Both) ____________

Uncorrected (L) ____________ (R) ____________ (Both) ____________

Eyes ____________
Ears (otoscopic) ____________
Nose ____________
Throat ____________
Teeth/Mouth ____________
Speech ____________
Balance ____________
Coordination ____________
Skin ____________
Lymphatic ____________
Lungs ____________ Chest contour ____________
Heart Rate ____________
Rhythm ____________
Murmur ____________

Cervical spine ____________
Back ____________ Scoliosis ____________
Shoulders ____________
Arm/Elbow/Wrist/Hand ____________
Knees/Hips ____________
Nutrition ____________
General Appearance ____________
Appropriate to chronological age ____________
Male Genitalia ____ Normal ____ Abnormal
Hernia ____ Normal ____ Abnormal
Testes ____ Normal ____ Abnormal
Present Bilaterally ____ Yes ____ No
Female Genitalia ____ Normal ____ Abnormal

Other ____________

Any recommendations or concerns on such items as:
Weight loss or gain; restrictions for weight loss: ____________
Other ____________

- **Please attach complete immunization record**

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics/physical education:

________ Full participation ________ Limited participation
________ No participation ________ Needs additional evaluation

If not cleared for full participation, give reasons and recommendations: ____________

____

Physician's signature ____________ Date: ____________

Physician's Name (print) ____________

Address ____________ City/State/Zip ____________

Phone ____________ Fax # ____________

Name:______________________________ Grade/Teacher:______________________

PART II MEDICAL HISTORY (This Page is to be completed by PARENT/GUARDIAN)

To be reviewed with your physician prior to and during the physical examination.. Please explain any "yes" answers.

Has this student ever had any of the following:

YES NO DATES

____ ____ ________ Take any **MEDICATION** regularly? If so, what?__________________
____ ____ ________ **Any prescription for use of: Adrenaline, Inhaler, other allergy medicine?** __________
____ ____ ________ Significant ALLERGIES to: Bee stings, foods, medicine, pollen, other __________
____ ____ ________ **Diagnosis of Asthma?** __________________
____ ____ ________ Seizures or epilepsy __________________
____ ____ ________ Broken bones ______________ Weak joints-ankles, knee, etc.__________
____ ____ ________ Spinal injury __________
____ ____ ________ Chicken Pox__________
____ ____ ________ Lyme Disease __________
____ ____ ________ Congenital defects__________________
____ ____ ________ Injury or illness that previously excluded athletic participation __________
____ ____ ________ Blood disorders including sickle cell trait, anemia, etc.? __________
____ ____ ________ Diabetes?__________ Family history?__________
____ ____ ________ Wear contact lenses, eyeglasses or dental appliance?__________
____ ____ ________ Ever been knocked out?__________ Concussion?__________
____ ____ ________ Ever been hospitalized?__________ Surgery?__________
____ ____ ________ Illness lasting a week or more, such as, mononucleosis? __________
____ ____ ________ Missing or non-functioning organs, i.e. testes, eye, kidney, etc.? __________
____ ____ ________ Skin conditions; rash, infection, or athlete's foot, etc.? __________
____ ____ ________ Experienced a significant change in weight; loss or gain?__________

CARDIOVASCULAR HISTORY:

____ ____ ________ Fainting or passing out?__________
____ ____ ________ Chest pain or discomfort with exercise? Did student ever need to stop running or exercising because of chest pain or shortness of breath?__________
____ ____ ________ Excessive or unexpected or unexplained shortness of breath associated with exercise?__________
____ ____ ________ Found to have a heart murmur?__________
____ ____ ________ High blood pressure (hypertension)? __________
____ ____ ________ Has a family member died prematurely (prior to age 50, sudden or otherwise)?__________
____ ____ ________ Is there any family history of significant disability due to cardiovascular disease in a close relative less than fifty years of age?
____ ____ ________ Do you have any specific knowledge of the occurrence of specific cardiovascular conditions such as hypertropic cardiomyopathy, dilated cardiomyopathy, long QT Syndrome, Marfan Syndrome, or clinically important arrhythmias?__________

Female Menstrual History: Age of onset __________
Are the cycles regular? __Yes __No Explain: __________
Any problems/severe pain? __Yes __No Explain: __________

Male Hx. Undescended Testicle __Yes __No
Testicular Surgery __Yes __No Date:__________

____ ____ ________ Have any other significant health problems? __________
____

Parent/Guardian Signature: ______________________ **Date:** __________