SAU #6 SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM
(To Be Completed by Physician)

Name: _____ **Date of Birth**: _____

List Any Routine Medications Currently Taking:

_____

List Any Medication Allergies Here: _____

**** PLEASE ATTACH A COPY OF ALL IMMUNIZATIONS****

HEALTH HISTORY (give dates):

Allergy _____ Heart Disease_____

Epi-Pen Required_____ Hospitalizations _____

Serious Injuries _____ Orthopedic_____

Ear Infections _____ Transplants_____

Concussion_____How Many_____Length of Treatment_____Current Status_____

Seizure Disorder_____Emergency Medication_____

Diabetes _____Treatment_____

Asthma_____Inhaler_____

*****AN EMERGENCY ACTION PLAN IS REQUIRED FOR: ASTHMA, DIABETES, SEIZURE AND ALLERGIES*****

PHYSICAL EXAM:

Normal _____

Exceptions/abnormalities _____

Vision		Blood Pressure		O2 Saturation	
Corrective Lenses		Heart Rate		Height	
Hearing		Respirations		Weight	
Hearing Aids/FM System		Temperature		**Lead Screening**	

DEVELOPMENTAL (PreK - 12th grade):

Normal _____**Delayed** _____

Recommendation regarding medical/developmental needs:_____

_____

MAY PARTICIPATE IN (Physical education classes, athletic programs, camps, field trips, after school activities):

ALL FORMS OF ATHLETICS FOR ONE CALENDAR YEAR: **YES** **NO**

ANY RESTRICTIONS:

_____

_____

COMMENTS_____

_____

DATE OF EXAM: _____ **PHYSICIAN SIGNATURE** _____

PHYSICIAN NAME_____

PHYSICIAN ADDRESS: _____ **PHONE NUMBER**:_____

PARENT/GUARDIAN SIGNATURE_____

****THIS FORM IS ONLY VALID ONE YEAR FROM DATE OF EXAM****

Rev. May 2017