

**2010-2011
PHYSICAL EXAMINATION
GERSTELL ACADEMY**

This form is to be completed by your Health Care Provider.

Name: _____ Date of Birth: _____ Grade: _____

Height: _____ Weight: _____ Blood Pressure: _____

****BMI or BMI for age percentile:** _____

Visual Acuity:

Without Glasses: R _____ L _____

With Glasses: R _____ L _____

Color Vision: _____

Contact Lenses: _____

Urinalysis:

Spec. Grav.: _____

ALB.: _____

Microscopic: _____

Glucose: _____

	Normal (Check)	Describe Abnormality		Normal (Check)	Describe Abnormality
Ears:	_____	_____	Abdomen:	_____	_____
Gross Hearing	_____	_____	Hernia	_____	_____
Nose:	_____	_____	Genitalia:	_____	_____
Teeth & Gums:	_____	_____	Skeleton:	_____	_____
Throat:	_____	_____	Spine	_____	_____
Lungs:	_____	_____	Musculature	_____	_____
Heart:	_____	_____	Neurological:	_____	_____
Murmurs	_____	_____	Emotional:	_____	_____
Skin:	_____	_____	Stability:	_____	_____

Immunizations – Students must comply with Maryland State immunization requirements for school attendance, and must have a Maryland Immunization Certificate on file.

Immunizations given: _____
(Give dates of additional boosters given since primary series was complete)

HISTORY: LIST AGE WHEN STUDENT HAD OR STARTED HAVING:

Allergies: _____	Kidney Disease: _____	Infectious Mononucleosis: _____
Asthma: _____	Heart Murmur: _____	Mental or Nervous Disorder: _____
Hay fever: _____	Convulsions: _____	Menstrual Onset: _____
Tonsillitis: _____	Epilepsy: _____	Overweight: _____
Ear Infections: _____	Diabetes: _____	Other: _____

Lead Screening (required for children <6 years of age only) Addendum form completed if applicable.
Yes ___ No ___

Operations: _____
Severe Injuries: _____
Food Allergies: _____
Drug Allergies: _____
Other Allergies: _____
Athletic Activities to be Restricted: _____
Medications – List all prescribed or taken on regular basis: _____

All medications to be taken at school must be administered through the Health Room. The “Medication Administration Authorization” form must be on file completed and signed by both a Parent and a Physician for each medication taken at school.

Suggestions or Comments: _____

DISCRETIONARY ITEMS The nurse or designee in her absence may administer the following over-the-counter items to this child as needed: (Check those we **MAY** give) Neosporin _____, Peroxide _____, Throat Lozenges/cough drop _____, Anti-itch lotion or spray (Cortisone) _____, Sunscreen _____, Rubbing Alcohol _____.

This student is in satisfactory condition and may engage in all usual activities, except as noted.

Physician’s Name: _____ (Please Print)

Address: _____

Telephone Number: _____

Physician’s Signature

Date