

NAME \_\_\_\_\_

Grade \_\_\_\_\_

Male/Female

## FRANKLIN REGIONAL SCHOOL DISTRICT PHYSICAL EXAM FORM

### IMMUNIZATIONS

**REQUIRED** for attendance in **ALL GRADES**, students need the following:

4 doses DTaP (1 to be administered after 4 <sup>th</sup> birthday)	#1 _____	#2 _____	#3 _____	#4 _____
3 doses of polio	#1 _____	#2 _____	#3 _____	
2 doses MMR	#1 _____	#2 _____		
3 doses of HEPATITIS B	#1 _____	#2 _____	#3 _____	
2 doses of VARICELLA (chickenpox)	#1 _____	#2 _____	OR documentation of disease _____ date	

**REQUIRED** for attendance into 7<sup>th</sup> grade year:

1 dose of Tdap	#1 _____
1 dose of Meningococcal Conjugate vaccine (MCV)	#1 _____

*Pennsylvania's school immunization requirements can be found in 28 Pa CODE CH.23 (school immunizations)*

### PHYSICAL

#### PART I

VITALS: B.P. \_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_ PULSE \_\_\_\_/\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

VISION: R \_\_\_\_ L \_\_\_\_ (Glasses, Contacts)

SYSTEMS: NORMAL COMMENTS IF ABNORMAL

ORTHO \_\_\_\_\_

NEURO \_\_\_\_\_

SCOLIOSIS \_\_\_\_\_

#### PART II

ENT/ SKIN \_\_\_\_\_

HEART \_\_\_\_\_

LUNGS \_\_\_\_\_

ABDOMEN \_\_\_\_\_

HERNIA \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

**PLEASE CIRCLE AND FILL IN DETAILS OF ANY "YES" ANSWER IN SPACE AT BOTTOM OF PAGE**

**FAMILY HISTORY**

**YES    NO**

1. Has any family member died of heart problems or sudden death before age 50? (excluding accidents) . . .
2. Does any close family member have: diabetes, migraines, asthma, heart trouble, elevated cholesterol . . .

**STUDENT HISTORY**

3. Have you **EVER** been unable to participate in a particular sport or told you should not participate in the future? Please explain below . . . . .
4. Have you **EVER** had any: . . . . .

- |                                    |   |   |   |
|------------------------------------|---|---|---|
| <input type="checkbox"/> Mono      | <input type="checkbox"/> TB                         | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Anemia or bleeding problem | <input type="checkbox"/> Stomach ulcer                        | <input type="checkbox"/> Hernia           |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Eye injuries or temp. loss of vision |   |

**STUDENT HISTORY IN THE PAST YEAR - If answer is "YES" please circle reason**

5. Have you been hospitalized or had surgery? . . . . .
6. Have you had any chronic or recurring illness lasting more than 1 week?. . . . .
7. Do you have any allergies: hayfever, hives, asthma, bee sting or medication? . . . . .
8. Are you currently taking any medication or any OTC meds or herbs? . . . . .
9. Have you passed out or felt dizzy during exercise? . . . . .
10. Have you had any heart trouble: murmur, racing, skipped beats, chest pain, or BP problems? . . . . .
11. Have you had a concussion, skull fracture, loss of memory or consciousness, seizure or headaches? . . . . .
12. Have you injured (sprained, dislocated, fractured, etc. . . **DURING THE PAST YEAR** (please date)

**Please specify left (L) or right (R)**

- |                                  |                                   |                                |                                    |                                   |                                   |                          |                          |
|----------------------------------|-----------------------------------|--------------------------------|------------------------------------|-----------------------------------|-----------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> neck    | <input type="checkbox"/> back     | <input type="checkbox"/> chest | <input type="checkbox"/> shin/calf | <input type="checkbox"/> testicle | <input type="checkbox"/> spleen   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> hand    | <input type="checkbox"/> elbow    | <input type="checkbox"/> hip   | <input type="checkbox"/> ankle     | <input type="checkbox"/> ovary    | <input type="checkbox"/> clavicle |                          |                          |
| <input type="checkbox"/> wrist   | <input type="checkbox"/> arm      | <input type="checkbox"/> thigh | <input type="checkbox"/> foot      | <input type="checkbox"/> kidney   |                                   |                          |                          |
| <input type="checkbox"/> forearm | <input type="checkbox"/> shoulder | <input type="checkbox"/> knee  | <input type="checkbox"/> eye       | <input type="checkbox"/> lung     |                                   |                          |                          |

13. Have you had  Hearing loss  Perforated eardrum  Recurrent ear infections. . . . .
14. Do you have any skin problems: (recurrent rash, fungal infection, ringworm, athletes foot, boils) . . . . .
15. Do you have any dentures, bridges, braces, tooth caps, dental implants or appliances? . . . . .
16. Do you smoke, drink alcohol, take drugs? . . . . .
17. **GIRLS!** When was your first period? \_\_\_\_\_ . Any menstrual problems? . . . . .

**IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN**

---



---



---

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE INFORMATION HEREIN IS **TRUE AND COMPLETE** AND GRANT PERMISSION FOR MEDICAL STAFF TO RELEASE ANY OF THE INFORMATION TO THOSE INDIVIDUALS DEEMED NECESSARY.

I GIVE MY CONSENT FOR THIS STUDENT TO PRACTICE AND PARTICIPATE IN ATHLETIC CONTESTS DURING THE \_\_\_\_\_ SCHOOL YEAR IN **ALL SPORTS EXCEPT** \_\_\_\_\_.

\_\_\_\_\_  
(Signature of parent /Legal guardian)

\_\_\_\_\_  
(Date)

**PHYSICAL EXAM CANNOT BE DONE BY SCHOOL PHYSICIAN WITHOUT COMPLETION OF THIS FORM AND PARENT SIGNATURE!**