ALLIANCE PUBLIC SCHOOL PHYSICAL

"SUCCESS FOR ALL STUDENTS"

NAME______________________________ SEX : M F D.O.B.__________ GRADE_____

PARENTS/GUARDIAN______________________________ PHONE______________

ADDRESS__________________________________

PHYSICAL FINDINGS

Height_______ Weight_______

Blood Pressure________ Pulse_______

Urinalysis____________________

Hemoglobin____________________

Evidence of scoliosis: No_____ Yes_____

Evidence of hernia: No_____ Yes_____

Does student have or previous had:

Diabetes______ Seizures______

Heart Disease______ Ulcers______

Hearing Loss______ Chicken Pox______

Hepatitis______ Mononucleosis______

Asthma______

Heart__________________________

Thyroid__________________________

Lungs__________________________

Abdominal organs____________________

Orthopedic Exam:

- Neck__________________
- Spine__________________
- Upper Extremities____________
- Lower Extremities____________
- Knees__________________
- Feet__________________

Allergies____

Operations or significant injuries (please list):__________________________

Required medications on a daily or episodic routine__________________________

____

Significant findings and remarks:________________________________

____

____

VISION EVALUATION

(Required for Kindergartners/Out-of-State Transfers)

May be done six months prior to student's entry.

REQUIRED TESTS	Pass	Fail	Recommended Further Evaluation (comments noted below)
Amblyopia	____	____	____
Strabismus	____	____	____
Internal Eye Health	____	____	____
External Eye Health	____	____	____
Visual Acuity	____	____	____

Right eye @ distance (20 ft.)	20/____	aided/unaided
Left eye @ distance (20 ft.)	20/____	aided/unaided
Right eye @ distance (16 in.)	20/____	aided/unaided
Left eye @ distance (16 in.)	20/____	aided/unaided

Comments:

Physician's Signature__________________________ Date__________

Student Name:______________________________Birth Date____________________

Address____

Grade______________ Age________________

Parents/Guardians name____

Home Phone_________________________Cell phone_________________________

Emergency Number___________________________

INSURANCE COMPANY:____

		YES	NO
1.	History of Diabetes in family--	____	____
2.	History of Epilepsy or other seizure disorders--------------------	____	____
3.	Has had injuries requiring medical attention ------------------------	____	____
4.	Has had illness lasting more than one week------- ------------------	____	____
5.	Is under physician's care now--	____	____
6.	Takes medication now---	____	____
7.	Wears glasses or contacts--	____	____
8.	Has been in hospital ---	____	____
9.	Has had surgical procedure---	____	____
10.	Do you know of any reason why this individual should not participate in all sports?	____	____

PLEASE EXPLAIN any "yes" answers to above questions____________________________

____

____

11.	Has seen dentist within past 6 months---------------------------	____	____
12.	Date of most recent tetanus immunization ________________		

PARENT SIGNATURE______________________________DATE________________

STUDENT SIGNATURE_____________________________DATE________________

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