# YEARLY PHYSICAL EXAMINATION
# School Year 2017-2018

Student Name _____ Male ☐ Female ☐ Birth Date _____

***DATE OF EXAM:*** _____ **Height_____ Weight_____ B/P _____ /_____ Pulse _____**

| | Normal | Describe Abnormal | | Normal | Describe Abnormal |
|---|---|---|---|---|---|
| Neurologic | | | Neck | | |
| HEENT | | | Shoulders | | |
| Heart | | | Arms/Hands | | |
| Lungs | | | Hips | | |
| Abdomen | | | Knees | | |
| Skin | | | Feet/Ankles | | |
| Past medical hx of: | | | | | |

****Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD,DO,PA or APRN)***

**Vision Screening**

| Type: | Right | Left |
|---|---|---|
| With glasses | 20/ | 20/ |
| Without glasses | 20/ | 20/ |

☐Referral made

**Auditory Screening**

| Type: | Right | Left |
|---|---|---|
| | *Pass* | *Pass* |
| | *Fail* | *Fail* |

☐Referral made

**Postural**

☐ No spinal abnormality

☐ Spinal abnormality:

*Mild* *Moderate* *Marked*

☐Referral made

**Health Conditions:**

Allergies ☐None ☐Yes*(circle one): *Life Threatening* *Non-Life Threatening* *Seasonal* *Contact*

Asthma ☐No ☐Yes*(circle one): *Intermittent* *Mild* *Moderate* *Severe* *Exercise Induced* *Cold Induced*

Diabetes ☐No ☐Yes*(circle one): *Type I* *Type II*

Seizures ☐No ☐Yes*(circle one): *Epileptic* *Rolandic* *Other*_____

**Action plan REQUIRED for all yes answers*

**Physical Activity:**

This student: ☐**MAY participate fully in school program/PE/athletics and competitive sports**

☐**MAY NOT** participate in school program/PE/athletics and competitive sports

☐Has **RESTRICTIONS** and a detailed note has been attached or previously submitted to the 'Iolani School Infirmary

**Medications:**

Daily: _____ PRN: _____

***Please complete Medication Administration Form for all medications to be administered by school nurse during the school day***

**IMMUNIZATIONS:** ☐Up to date ☐ New student **MUST ATTACH IMMUNIZATION RECORD** ☐Tetanus updated and charted below

| DTP. DTaP, DT or Td,Tdap | | Other | | Other | |
|---|---|---|---|---|---|
| Type | Date | Type | Date | Type | Date |
| | | | | | |

Tuberculosis Examination -Required for ALL new students and ALL grade 7 (unless entered 'Iolani School in grade 6)

| Intradermal | Date given | Date Read | Results (mm) | Practitioner |
|---|---|---|---|---|
| | | | | |
| Chest x-ray | Date | Results | Location | Practitioner |
| | | | | |

**PHYSICIAN: I hereby certify that I have examined this student and reviewed the immunization record.**

_____

**Signature of U.S. Licensed Practitioner (MD,DO,PA or APRN)** **Date Signed** **Printed/Stamped Name and Phone Number**