

HUTCHINSON PUBLIC SCHOOLS
PHYSICAL EXAMINATION RECORD

Child's Name _____ Age _____ Date of Birth _____
Mo Day Year

Parent's Name _____ Address _____ Phone _____

Check the following conditions and diseases the child has had:

Conditions:

Allergies _____
Asthma _____
Diabetes _____
Epilepsy _____

Heart _____
Hernia _____
Kidney _____
Orthopedic _____

Diseases:

Chicken Pox _____
Rheumatic Fever _____
Scarlet Fever _____

Has this child ever been hospitalized _____ Why? _____

MEDICAL EXAMINATION BY HEALTH CARE PROVIDER

Height: _____ Weight: _____ Vision: OD 20/____ OS 20/____ OU 20/____

COMMENTS

Eyes _____
Ears _____
Nose _____
Throat _____
Teeth _____
Heart _____
Lungs _____
Skin _____
Hernia _____
Genitalia _____
Orthopedic _____
Speech _____

LABORATORY TESTS

Hemoglobin _____ U.A. _____

Are there any activities in which this student should not participate?

Date: _____

Health Care Provider

Address: _____

City, State _____

Phone: _____