Primrose Elementary School
PO Box 630
Lincolndale, New York 10540
(914) 248-8888 fax (914) 248-5384

PHYSICAL EXAMINATION FORM

Name:_____**Date of exam**_____**Grade**_____
(last) (first) (m.i.)

Date of birth_____**Sex**_____

Mailing Address:_____
PO box, house #, street Town State Zip

Part A: Physical Examination:

(To be completed by a Licensed Physician or Nurse Practitioner)

N= Normal
X=Abnormal

Height	_____	Ears	_____	Genitourinary	_____
Weight	_____	Throat	_____	Hernia	_____
Blood Pressure	_____	Teeth	_____	Skin	_____
Pulse	_____	Thyroid Gland	_____	Extremities	_____
Eyes	_____	Lymph Glands	_____	Scoliosis	_____
Visual Acuity	R_____L_____	Heart	_____	Nervous System	_____
Corrected	R_____L_____	Lungs	_____		

Explanation of abnormal finding(s) above:_____

Part B: Interim Health History

(To be completed by a Licensed Physician or Nurse Practitioner)

1. Is child taking any medications on a regular basis at home or at school? Yes ( ) No ( )
2. Any hospitalizations or surgery during the past year? Yes ( ) No ( )
3. Any allergies, asthma, or communicable diseases? Yes ( ) No ( )
4. Any significant illness, injury, fractures during the past year? Yes ( ) No ( )
5. Any abnormality that would interfere with school activities? Yes ( ) No ( )
6. Is child under treatment for any condition at this time? Yes ( ) No ( )
7. Any physical activity or sport in which the student should **not** participate? Yes ( ) No ( )

If YES to any of the above, please describe fully _____
_____
_____

Examining Physician _____Date _____
Physician's signature and stamp required