

**LAKE SHORE CENTRAL SCHOOLS
HEALTH SERVICES**

**PHYSICAL EXAMINATION FORM
PRE-K-12**

**The Education Law requires that every child in Pre-Kindergarten, Kindergarten, Grade 2,
Grade 4, Grade 7 and Grade 10, plus all NEW students, have a physical examination**

Name: _____ Gender: ___M___F DOB: _____

Date of Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

BMI Percentile: _____		Weight Status Category	
_____ Less than 5th	_____ 5th through 49th	_____ 50th through 84th	
_____ 85th through 94th	_____ 95th through 98th	_____ 99th and higher	

Urine: Protein: _____ Glucose: _____ Sickle Cell Screen: Positive: _____ Negative: _____ Not Done: _____

Eyes: (R _____ (L) _____ Corrective Lens: Glasses: _____ Contact Lenses: _____

Hearing (Otosopic): _____ Defects: _____ Nutrition: _____

Ears: _____ Eyes: _____ Nose: _____

Lymph Nodes: _____ Thyroid: _____ Tonsils: _____

Teeth: _____ Heart: _____ Lungs: _____

Genito-Urinary: _____ Hernias: _____ Tanner: I. II. III. IV. V.

Females Only: Have you started your menstrual cycle? ___ Yes ___ No If yes, what year _____

Nervous System: _____ Skin: _____

Orthopedic-Structural-Postural-Feet: _____

Scoliosis: _____ Negative: _____ Positive: _____

Chronic Condition: _____

Specify Any Abnormality: _____

Approved for sport activity: _____ Disqualified: _____ Reason: _____

Comments: _____

PRINTED Physician Name: _____ **Phone:** _____

Physician Signature: _____ **Date:** _____

Physician Stamp / Address

PLEASE RETURN THIS COMPLETED FORM TO THE SCHOOL HEALTH OFFICE