School Name: ______________________
School Fax: ______________________

Physical Exam Form C

Manchester Health Department
1528 Elm Street
Manchester NH 03101
Tel: (603) 624-6466

Instructions to Parent: In order to best meet your child's educational and health needs in the school setting we need background information relating to the child's current health status. Please have your medical provider fill out this form and return it to the school. **Physician/Provider may complete his/her own physical exam form.**

Name: ____DOB: ____________

Height: ________________ Weight: ________________ BMI: ____________ Ref: Yes / No _________

Scoliosis: Screen: _________ Ref: Yes / No ________ B/P: ____________Ref: Yes / No __________

HEALTH ASSESSMENT:

Complete each line	Normal	Abnormal	Needs Follow-Up	Not Examined
Lead Level				
Vision / Right				
Vision / Left				
Hearing / Right				
Hearing / Left				
Skin/Scalp				
Nutrition				
Neurological & Muscular				
Spine & Extremities				
Eyes				
Ears				
Nose, Throat, Mouth				
Glands (including Thyroid)				
Chest, Breasts				
Heart, Lungs				
Abdomen				
Genitalia				

A. Any chronic illness that may require medication or special accommodations in school (e.g. seizure disorder, food, allergies, asthma)? (*Medication taken during school hours, requires a written physician's order)*

B. Pertinent past family/medical history

C. Developmental/Psychosocial /Emotional Assessment:

D. Updates in Immunizations Boosters given:
Attach updated Immunization Record

The above named patient has been determined to be in good health and may participate in day care, school, sports, camp with:

Restrictions: ______________________________________**No restriction**___________ **Date of Exam:** _____________

Licensed Provider's Signature: ____**Date**___________

Licensed Provider's Name: (Please print): ____