Pennsylvania
School for the Deaf
100 West School House Lane | Philadelphia, PA 19144-3404
1-215-951-4700 V | 1-215-951-4708 F | www.psd.org

# PHYSICAL EXAM

*to be completed by your child health care provider*

**NAME:** _____ **DOB**:_____ **SEX:** [ ] Male [ ] Female
Last First M.I.

**ALLERGIES:**
[ ] Food_____
[ ] Medication_____
[ ] Environmental_____

*Is Epinephrine Injector needed*? [ ] YES [ ] NO

**IMMUNIZATIONS:**
[ ] Immunization Record Attached [ ] Up-To- Date [ ] Provisional (attach vaccination plan)
[ ] Medical Exemption Date Issued: _____ Reason: _____ Date Rescinded: _____

**TB STATUS:**
[ ] Low risk per Pediatric Risk Assessment Questionnaire (AAP)
[ ] Mantoux: Applied date _____ Read date_____ Result/Follow up _____

**LEAD EXPOSURE STATUS:**
[ ] Low risk
[ ] **Blood Level Testing** Date: _____
[ ] Normal [ ] Abnormal Lead Level _____ Follow up Treatment: _____

**Please CHECK/ MARK**:

**[ ] Yes, this child appears FREE from contagious or communicable disease**

**[ ] No, this child is NOT FREE from contagious or communicable disease**
These precautions are needed: _____

**HISTORY OF PAST HOSPITALIZATIONS AND/OR SURGERIES:**
_____
_____
_____

**MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION**
(Attach additional page if needed)

Student Name: _____ D.O.B._____

| Date of Exam:_____ | CHECK ONE NORMAL | *ABNORMAL | DEFER | *ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS |
|---|---|---|---|---|
| Height: ( ) inches | | | | |
| Weight: ( ) pounds | | | | |
| BMI: ( ) | | | | |
| BMI-for-Age-Percentile: ( )% | | | | |
| Pulse: ( ) | | | | |
| Blood Pressure: ( / ) | | | | |
| Hair/Scalp | | | | |
| Skin | | | | |
| Eyes/Vision Corrected | | | | |
| Ears/Hearing | | | | |
| Nose and Throat | | | | |
| Teeth and Gingiva | | | | |
| Lymph Glands | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Genitourinary | | | | |
| Neuromuscular System | | | | |
| Extremities | | | | |
| Spine (Scoliosis) | | | | |
| Other | | | | |

**Name of Examiner:** _____ **Exam Date:** _____
**Office Phone:** _____ **Office Fax:** _____
**Signature:** _____MD/DO, PA, CRNP

**RECOMMENDED TEST/FOLLOW-UP:** (*Please indicate date of appointment or plan*)
[ ] Occupational Therapy [ ] Counseling/ Mental health_____ [ ] Dental_____
[ ] Physical Therapy [ ] Medical Specialty_____ [ ] Other_____
Recommendations: _____

**EXPANDED PHYSICAL FOR SPORTS PARTICIPATION**

| | Normal | Abnormal | If Abnormal, Explain |
|---|---|---|---|
| • **Musculoskeletal/Orthopedics** | | | |
| • **Cervical/Shoulders** | | | |
| • **Arms/Elbow/Wrist/Hand** | | | |
| • **Hip/Knees/Ankles** | | | |

A. Cleared _____
B. Cleared after completing evaluation/rehabilitation for : _____
C. Not cleared for: [ ] Collision [ ]Contact [ ]Non- Contact
[ ] Strenuous [ ] Moderately Strenuous [ ] Non Strenuous
Not Cleared Due to: _____
Recommendations: _____