PHYSICAL EXAMINATION FORM

Please complete top of form and take to your physician at the time of examination

NAME: ______________________ DOB: ______________ GRADE: ______

ADDRESS: ____

PARENT/GUARDIAN NAME: ______________________________

HEALTH HISTORY

Please check the boxes that apply:

☐ Allergy	☐ Convulsions	☐ Heart Disease	☐ Serious Injury
☐ Asthma	☐ Diabetes	☐ Operations	☐ Strep Throat
☐ Chicken Pox	☐ Ear Infections	☐ Mumps	☐ Tuberculosis

☐ Other: ______________________________________

TO BE COMPLETED BY EXAMINING PHYSICIAN

This student, ______________________, date of birth, ______________

has been examined by me, on ______________________ with the findings as follows:

Essentially negative and no restrictions ______________________________

SCREENINGS:

VISION: L: ________ R: ________ HEARING: L: ________ R: ________

Any known defects: ______________________________________

Allergies: ____

Special Medication: ______________________________________

Type: ______________________ Reason: ______________________

Restrictions: ____

Recommendations: ____

____

I hereby certify that this student was given a complete medical examination according to New Hampshire state law.

______________________________ ______________________
Licensed Physician's Signature Date

______________________________ ______________________
Licensed Physician (Print Name) Phone