

PHYSICAL EXAMINATION FORM

NAME:DOB:GRADE: ADDRESS: PARENT/GUARDIAN NAME: PARENT/GUARDIAN NAME: PARENT/GUARDIAN NAME: PARENT/GUARDIAN NAME: PARENT/GUARDIAN NAME: Asthma Convulsions Bear Infections Operations Strep Throat Asthma Diabetes Operations Strep Throat Chicken Pox Ear Infections Other:, date of birth, has been examined by me, on, date of birth,, date of birth,, has been examined by me, on, date of birth, has been examined by me, on, date of birth,	Please complete to	op of form and take to ye	our physician at the t	ime of examination	
ADDRESS:	NAME:		DOB:	GRADE:	
HEALTH HISTORY 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,					
Please check the boxes that apply:	PARENT/GUARDIAN NAM	IE:			
Allergy Convulsions Heart Disease Serious Injury Asthma Diabetes Operations Strep Throat Chicken Pox Ear Infections Mumps Tuberculosis Other:		HEALTH	HISTORY		
Asthma Diabetes Operations Strep Throat Chicken Pox Ear Infections Mumps Tuberculosis Other:	Please check the boxes that a	oply:			
Chicken Pox Ear Infections Mumps Tuberculosis Other: TO BE COMPLETED BY EXAMINING PHYSICIAN This student, Adate of birth, has been examined by me, on SCREENINGS: VISION: L: R: HEARING: L: R: Reason: Reason: Reason: Recommendations: <i>I hereby certify that this student was given a complete medical examination according to New Hampshire state law.</i>	□ Allergy	□ Convulsions	□ Heart Disease	□ Serious Injury	
Coher:	🗆 Asthma	□ Diabetes	\Box Operations	□ Strep Throat	
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: Any known defects:	□ Chicken Pox	□ Ear Infections	□ Mumps	□ Tuberculosis	
This student,, date of birth, has been examined by me, on with the findings as follows: Essentially negative and no restrictions	□ Other:				
has been examined by me, onwith the findings as follows: Essentially negative and no restrictions SCREENINGS: VISION: L:R: HEARING: L:R: Any known defects: Allergies: Special Medication: Special Medication: Reason: Restrictions: Recommendations: I hereby certify that this student was given a complete medical examination according to New Hampshire state law.	TO BE COMPLETED BY EXAMINING PHYSICIAN				
Essentially negative and no restrictions	This student,		, date of birth,		
Essentially negative and no restrictions	has been examined by me, on			with the findings as follows:	
SCREENINGS: VISION: L:					
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.					
Allergies: Special Medication: Type: Type: Restrictions: Recommendations: I hereby certify that this student was given a complete medical examination according to New Hampshire state law.	VISION: L:	R:	HEARING: L:	R:	
Special Medication:	Any known defects:				
Type: Reason: Restrictions: Recommendations: <i>I hereby certify that this student was given a complete medical examination according to</i> <i>New Hampshire state law.</i>	Allergies:				
Restrictions: Recommendations: I hereby certify that this student was given a complete medical examination according to New Hampshire state law.	Special Medication:				
Restrictions: Recommendations: I hereby certify that this student was given a complete medical examination according to New Hampshire state law.					
Recommendations:					
I hereby certify that this student was given a complete medical examination according to New Hampshire state law.					
New Hampshire state law.					
New Hampshire state law.	I hereby certify that this student was given a complete medical examination according to				
Licensed Physician's Signature Date					
Licensed Physician's Signature Date					
	Licensed Physician's Signature		Date		
Licensed Physician (Print Name) Phone	Licensed Physician (Print Name)		Phone		