

Port Jervis School District Physical Form
 High School Health Office – Phone – 845-858-3125 Fax 845-858-2895
 Middle School Health Office – Phone 845-858-3161 Fax 845-858-2893
 Anna S. Kuhl Health Office – Phone 845-858-3193/3203 Fax 845-858-2894
 Bicentennial Health Office – Phone 845-754-8325 Fax 845-754-7355

Student Name: _____ Date of Birth: _____ Age: ____ Gender: ____
 Height: _____ Weight: _____ Body Build: Slender ____ Medium ____ Heavy ____ Obese ____
 Vision without glasses R 20/____ L 20/____ With glasses/contacts R 20/ ____ L 20/____
 Hearing Sweep 20 R ____ L ____ Blood Pressure _____ Pulse _____
 Urine analysis _____ Sugar _____ Protein _____ Blood _____

Please list any medications (prescription and non prescription) that the child is presently taking:

Does the child have any history of the following? If yes, please be specific and provide dates.

Asthma _____ Epilepsy _____
 Heart Disease _____ Murmur _____
 Diabetes _____ ADD/ADHD _____
 Fractures _____ Emotional Problems _____
 Allergies _____ Head Injury _____
 Other _____

Physical Findings:

Check One	Normal	Abnormal	Check One	Normal	Abnormal	Check One	Normal	Abnormal
Eyes			Heart			Abdomen		
Ears			Speech			Orthopedic		
Nose			Tonsils			Hernia		
Lungs			Lymph nodes			Scoliosis Screening		
Skin			Thyroid			Genitalia		
Teeth			Nervous System			Tanner I.	II.	III. IV. V.

The school health service will be glad to cooperate with you if your patient has a health problem, which might affect his/her education. Please answer the following questions including explanations if necessary.

Is there any abnormality listed which would interfere with school activities? Yes ____ No ____
 If so, what is it and how would it be limiting? _____

Is there any abnormality of the special senses, which would impede the learning process? Yes ____ No ____
 Please describe _____

Is there any physical activity or sport in which the pupil should not participate? Yes ____ No ____
 Please describe _____

Are there any problems with growth or nutrition with which the school should be acquainted? Yes ____ No ____
 Please describe _____

PLEASE PROVIDE A COPY OF CHILD'S CURRENT IMMUNIZATIONS

Physicians Name (please print) _____ Phone Number _____

Physician's Address _____

Physician's Signature _____ Date of Examination _____