PORTSMOUTH CHRISTIAN ACADEMY AT DOVER

PHYSICAL EXAMINATION FORM

20 Seaborne Drive, Dover, NH 03820 (603) 742-3617 LS fax (603) 750-0490 US fax: (603) 750-0489

Student: _____

School year: _____ Age:_____ DOB:_____ Grade:_____

Address: _____

Home Phone: _____

Parent: _____ Work Phone: _____

Physician: _____ Phone: _____

	Yes	No
1. Have you ever been hospitalized?	☐	☐
2. Have you ever had surgery?	☐	☐
3. Are you presently taking medications?	☐	☐
4. Have you ever passed out during or after exercise?	☐	☐
5. Have you ever been dizzy during or after exercise?	☐	☐
6. Have you ever had chest pains during or after exercise?	☐	☐
7. Do you tire more quickly than your friends?	☐	☐
8. Have you ever had high blood pressure?	☐	☐
9. Have you ever been told you had a heart murmur?	☐	☐
10. Have you ever had racing of your heart or a skipped heartbeat?	☐	☐
11. Has anyone in your family died suddenly or of heart problems before age 50?	☐	☐
12. Do you have any skin problems (itching, rashes, acne)?	☐	☐
13. Have you ever had a head injury?	☐	☐
14. Have you ever been knocked out or unconscious or had a seizure?	☐	☐
15. Have you ever had a pinched nerve?	☐	☐
16. Have you ever had muscle cramps?	☐	☐
17. Do you have trouble breathing or do you cough after activity?	☐	☐
18. Do you have any special equipment (braces, eye guards, etc.)?	☐	☐
19. Have you had any problems with your eyes or vision or do you wear contacts or glasses?	☐	☐
20. Have you had any problems with bones or joints (sprains, broken bones or repeated swelling, etc)?	☐	☐
21. Have you had any other medical problems?	☐	☐

22. Girls: When was your first menstrual period? _____

When was your last menstrual period**?** _____

What was the longest time between periods last year? _____

Please explain any "yes" answers: _____

_____

_____

_____

Medications: _____

Please attach a current copy of the immunization record.

PHYSICAL EXAMINATION FORM

Student Name _____ DOB _____

Height: _____ Percentile: _____ B/P: _____ U/A: _____
Weight: _____ Percentile: _____ Pulse: _____ Hgb/Hct: _____
Allergies: _____

	Normal	Abnormal	If abnormal, explain:
Hair/Scalp	☐	☐	_____
Skin	☐	☐	_____
Eyes – visual acuity R____ L____	☐	☐	_____
Eyes – color vision	☐	☐	_____
Hearing – dB R____L____	☐	☐	_____
Nose and Throat	☐	☐	_____
Teeth and Gingiva	☐	☐	_____
Speech	☐	☐	_____
Lymph Glands	☐	☐	_____
Cardiovascular	☐	☐	_____
Respiratory (asthma, etc.)	☐	☐	_____
Abdomen	☐	☐	_____
Gastrointestinal	☐	☐	_____
Genitalia	☐	☐	_____
Neurological	☐	☐	_____
Seizure Disorders	☐	☐	_____
Muscular System	☐	☐	_____
Extremities	☐	☐	_____
Orthopedic (including scoliosis)	☐	☐	_____
Other	☐	☐	_____

*Impression of child's present state of health:_____

*Restrictions from sports/activities:_____

*Recommendations regarding:
Medical needs:_____
Developmental needs:_____
Family support: _____

_____ _____
Signature of physician/ARNP/PA Date

_____ _____
Printed name of physician/ARNP/PA Phone

Please return to:

School Nurse, Portsmouth Christian Academy, 20 Seaborne Drive, Dover, NH 03820
(603) 742-3617 LS fax (603) 750-0490 US fax (603) 750-0489