Glens Falls City School District
Glens Falls, New York
STUDENT PHYSICAL EXAMINATION RECORD

Sports Physical Yes / No
Sport:________________

Date: ________________ School: __________________________

Student's Last Name	Student's First Name	DOB	Age	Sex	Grade
Parent's Name		Work Phone			
Home Address	Home Phone	Cell Phone			

PLEASE LIST ALL INFECTIONS OR CONDITIONS YOUR CHILD HAS HAD:

Illnesses:_______________Surgeries:________________Chronic Conditions:________________
Allergies: Y N Medications:____
Foods:____
Other:____
Does your child require a special diet? Y N Describe:___________________________________
Does your child take medication regularly? Y N List Meds:_______________________________
Are there any side effects we should be aware of? Describe:_______________________________
Are there any restrictions to physical education? Y N Describe:_________________________

Antigen	First Date	Second Date	Third Date	Fourth Date	Fifth Date
Hep B/Hib					
Dtap					
Polio					
MMR			XXXXXXXX	XXXXXXXX	XXXXXXXX
Hib					
Hep B				XXXXXXXX	XXXXXXXX
Varicella					
Prevnar					
Td					
Other					

PHYSICAL EXAMINATION N=Normal X =Defect

Height (inches):______ Weight (lbs):______ BMI:_______ BP:_____ Pulse: ____General Appearance:_______
Eyes (Visual Acuity): R__________ L_____________ With Glasses/Contacts: R_________ L_________
Ears (Hearing): R__________ L_____________ Otoscope: R_________ L_________
Nutrition:____ Lungs:____
Nose:____ Heart:____
Spine:___________ Scoliosis? Y N Murmur:______________________________________
Dental:____ Rhythm:______________________________________
Orthodontic:________________________________ Abdomen:_____________________________________
Throat:____ Hernias:______________________________________
Speech: ____ Genitourinary:________________________________
Skin:____ Nervous System:_______________________________
Glands: ____ Epilepsy:_____________________________________
Behavioral/Psych: ADD____ OCD____ ODD_____ Other:___________________________________
Other:____
Any modifications to school program? Y N Comments:____
Any restrictions to physical education? Y N Comments:____
Special Services? Y N Comments:____

Physician's Comments:____
Physician's Signature:____Date:___________Phone:________________
(If additional space is needed, please use back of form.)

Form #3 KC Updated 5/07