

Five Towns CSD

Camden Hills Regional High School
Janis Hogan RN, School Nurse
25 Keelson Dr. Rockport, ME 04856
236-7800 Ext 250; Fax 236-7813

PHYSICAL EXAMINATION

STUDENT NAME: _____

Grade: _____ Date of Physical: _____

Examination Data:

HEIGHT: _____ WEIGHT: _____ BMI: _____

VISION SCREENING: _____ EARS: _____

BLOOD PRESSURE: _____ NUTRITION: _____

HISTORY of ALLERGY: _____

ASTHMA: _____ TRIGGERS: _____ MEDS: _____

GENITALIA (MALES): _____ MENSTRUATION: _____ TANNER: _____

SPINAL SCREENING RESULTS:

KNOWN MEDICAL CONDITIONS: _____

STUDENT ON ANY ROUTINE MEDICATIONS: _____

REMARKS: _____

HEALTHY CHILD WITH NO RESTRICTIONS ON PHYSICAL ACTIVITY _____

Remainder of physical exam was found to be normal unless noted below.

IMMUNIZATIONS: The state requires that a physician verified list of immunizations with the full dates listed be in each student's health record. If this has not previously been sent, would you please enclose?

Physician: _____ Phone _____

Address: _____ Date _____