

THREE VILLAGE CENTRAL SCHOOL DISTRICT  
SECONDARY PHYSICAL / HEALTH APPRAISAL

Rev 10/2011

Name: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

PHYSICAL EXAM

ALLERGIES: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Resting Pulse: \_\_\_\_\_

<b>REQUIRED:</b>	<b>REQUIRED:</b>
Body Mass Index : _____	Weight Status Category (BMI Percentile): <input type="checkbox"/> less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher

**REQUIRED:**  
**SPECIFY CURRENT DISEASES:**

ASTHMA   
  DIABETES TYPE 1   
  DIABETES TYPE 2   
  HYPERLIPIDEMIA   
  HYPERTENSION

Vision – <u>Uncorrected</u> :	R	L
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Vision – <u>Corrected</u> :	R	L
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**AUDIOMETRY MUST INCLUDE VALUES:**

AD 500	1000	2000	4000	Hz
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**AUDIOMETRY MUST INCLUDE VALUES:**

AS 500	1000	2000	4000	Hz
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**URINALYSIS:**

SPEC. GRAV	PRO.	GLUC.	MICRO
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**TANNER:**

I.	II.	III.	IV.	V.
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**EXAM ENTIRELY NORMAL**  
Specify any abnormality (use reverse of form if needed): \_\_\_\_\_

MEDICAL	NORMAL	ABNORMAL FINDINGS	MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
APPEARANCE			CONCUSSION	DATE:	
EYES/EARS/NOSE/THROAT			SCOLIOSIS / SPINE		
LYMPH NODES			SHOULDER/ARM		
HEART/MURMUR			ELBOW/FOREARM		
PULSES			WRIST/HAND		
LUNGS			HIP/THIGH		
ABDOMEN			KNEE		
GENITALIA			LEG/ANKLE		
SKIN			FOOT		
HERNIA					

PHYSICAL EDUCATION / SPORTS / WORK QUALIFICATION / CSE CONSIDERATION

***District Chief Medical Officer use only:***

Approved as Requested: \_\_\_\_\_  
 Approval Deferred \_\_\_\_\_  
 Approved with Modification \_\_\_\_\_

District Chief Medical Officer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Private Medical Doctor Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Stamp: \_\_\_\_\_  
Name/Address: \_\_\_\_\_

I hereby give permission for my child to have a health appraisal/physical by the school physician

Parent Signature: \_\_\_\_\_ Parent Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_