

PHYSICAL EXAMINATION FORM
CALEDONIA-MUMFORD CENTRAL SCHOOL

Student Name: _____
 Address _____
 Physician: _____
DENTAL REFERRAL: Yes ___ No ___ Date _____

Date of Birth _____
 Phone Number _____
 Grade Level _____
 Gender: M F

NEW REQUIREMENT Body Mass Index: _____ - _____ Weight Status Category (BMI Percentile): ___ less than 5% ___ 5th thru 49th ___ 50th thru 84th ___ 85th thru 94th ___ 95th thru 98th ___ 99th and higher Specify currant diseases: Asthma ___ Diabetes: ___ Type 1 ___ Type 2 Hyperlipidemia ___ Hypertension ___ Other: _____	DATE OF EXAM: _____ Height: _____ Weight: _____ B.P. _____ Pulse _____
Allergies: LIFE THREATENING _____ Food _____ Insect _____ Other _____ Seasonal _____ Medication: _____	

Check here if entire exam is normal

Vision: without corrective lenses	R	L
Vision: with corrective lenses	R	L
Vision: Near Point	R	L
Hearing:	R	L

General Appearance	Normal	Abnormal
Skin		
Heart		
Lungs		
Abdomen		
G.U.		
Musculoskeletal		
Neurological		
Scoliosis:	Negative	Positive
Tanner Level	I II III IV V	

Immunization Record (Dates):

DTP/DTaP
 #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

 Dt or DT
 #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

 Sabins OPV
 #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

 IPV/EIPV
 #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

 MMR #1 _____ #2 _____

 Hepatitis B #1 _____ #2 _____ #3 _____

 Sickle cell Screening _____
 Varicella _____
 Other _____
Communicable Diseases(years contracted):
 Chicken Pox _____
 Other _____

Serious Illness NO [] YES [] _____
 Serious Injury NO [] YES [] _____
 Operations NO [] YES [] _____
 Bee Sting Allergy NO [] YES [] _____
 Allergies NO [] YES [] _____
 Taking Medication? NO [] YES [] _____

Physical Education/Sports/Playground/Work Qualification: Check all that apply.

- Contact/Collision Sports: basketball, football, soccer, wrestling, lacrosse, hockey
 Non-Contact/Strenuous: cheerleading, skiing, volleyball, track&field, cross-country, running, gymnastics
 Non-Strenuous: badminton, bowling, golf, table tennis, tennis, archery
 Physical Restrictions: (list if any)

Signature of Physician: _____ Date _____
 Printed Name of Physician: _____ Phone # _____
 Address _____

Please return form to Parent or Mail to: Caledonia-Mumford School 99 North St. Caledonia, NY 14423

Elementary: Brenda Kemp Middle/High: Meg Geer
 Fax: 585 538-3460 Fax: 585 538-3496