

Camden Hills Regional High School

PHYSICAL EXAMINATION FORM

Student Name: _____ Grade: ____ Date of Birth: _____

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 noted be included in each student's health record. If this has not previously been sent, please enclose it with this form.

Physician: _____ Date _____

Phone _____

Address: _____

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