PARKWAY SCHOOL DISTRICT

REPORT OF PHYSICAL EXAMINATION
(Grades K - 8)

Physical examinations are recommended upon entrance into school and at the beginning of the 3rd, 6th, and 9th grades. The Missouri State High School Activities Association requires a yearly physical examination prior to participation in inter-scholastic athletics in grades 9 through 12.

So much of your student's success and happiness in school and in life are dependent upon his/her physical and mental health that we are confident this information is vital in providing the best school life for your student. We shall appreciate your cooperation and help in this important matter.

Keith A. Marty
Superintendent

School ____ Current Grade___________

Student's Name____
(last) (first) (middle)

Date of Birth _______________________ Gender: ❑ Male ❑ Female

Father/Guardian ____

Mother/Guardian ____

Physician ___________________________________Phone ______________

Dentist _____________________________________Phone ______________

Orthodontist _________________________________Phone ______________

1. HISTORY OF IMMUNIZATION

REQUIRED BY MISSOURI STATE LAW

Please attach a **COPY** of student's permanent immunization record from your health care provider, Health Department, or previous school. Month, day, and year must be provided for all immunizations received, including infant series.

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Parkway School District Form #208 (Rev. 7/5/12)

2. HISTORY OF ILLNESS

Enter the year(s) in which your student had the following:

ANEMIA	_________	MUMPS	_________
ASTHMA	_________	PNEUMONIA	_________
CHICKEN POX	_________	RHEUMATIC FEVER	________
DIABETES	_________	RUBELLA	_________
HEPATITIS [JAUNDICE]		SCARLET FEVER	_________
(Specify Type - A, B, C, D or E)	_________	SEIZURE DISORDER	________
MEASLES	_________	STREP THROAT	_________
MENINGITIS	_________	TUBERCULOSIS	_________

3. HEALTH INFORMATION

Please list any allergies, injuries, operations, serious illnesses, heart conditions, vision problems, hearing loss, and any other health information you feel would be helpful:

____

____

____

Dental (dental bridges, false teeth, etc.)

____

Is your student on medication at home or school? ❑ Yes ❑ No

Specify name of medication(s), dosage, reason prescribed:

____

____

Is your student currently under medical care? ❑ Yes ❑ No

Specify:

____

____

____

HEALTH INFORMATION cont.

	YES	NO
Do you have any concerns about your student's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin)?		
Does your student have any eye problems (difficulty seeing, lazy eye, crossed eyes, frequently reddened or watery eyes)?		
Does your student have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)?		
Does your student have any speech problems (stammering, stuttering, delayed speech development, etc.)?		
Does your student have frequent colds, sore throats, nosebleeds, persistent cough, shortness of breath?		
Does your student have any other specific sickness or problem which might, in your opinion affect his/her school performance or program?		

REMARKS: (Please explain any "yes" answer)

____

____

Has your student had an eye examination? ☐ Yes ☐ No Date _________

Glasses/Contact lens ☐ Yes ☐ No

Does your student have a periodic physical? ☐ Yes ☐ No

Does your student have periodic dental care? ☐ Yes ☐ No

When was last date seen by dentist? ______________________

Other information which will help us meet the needs of your student:

____

____

____

NOTE: PHYSICIAN TO COMPLETE

4. PHYSICAL FINDINGS

Height	________	Weight	________
Pulse	________	Blood Pressure	________
Nutrition	________	Skin	________
Scalp	________	Teeth	________
Gums	________	Nose	________
Throat	________	Ears	________
Eyes	________	Heart	________
Lymph	________	Lungs	________
Abdomen	________	Orthopedic	________
Scoliosis	________	Neurological	________
Urine	________	Hernia	________

Lead Screening Date ________ Result ________

T.B. Screening Date ________ Result ________

Significant concerns:______________________________

____

____

Do immunizations comply with Missouri State Law? ☐ Yes ☐ No

Can student carry a full program of schoolwork? ☐ Yes ☐ No

Should physical activity at school be restricted? ☐ Yes ☐ No

If YES, please state to what extent and for how long.

____

Is special seating recommended? Specify: ______________________

______________________________ ____________

Signature of Physician Date of Examination