

MONTICELLO CENTRAL SCHOOL DISTRICT MULTIPURPOSE PHYSICAL EXAMINATION

Name _____ DOB: _____ Grade: _____

Address: _____ Phone: _____

School: _____

Significant Family History: _____

Significant Medical History/Surgeries: _____

Significant Medical Issues: _____

MEDICATIONS: _____ None: _____

ALLERGIES: _____ None: _____

Date of Physical Exam: _____

Height _____ Weight _____ B/P _____ HR _____ BMI _____ WSC _____

Vision L20/_____ R20/_____ Hearing R _____ L _____

Eyes _____	WNL	Nervous System _____	WNL
Ears (Otosopic) _____	WNL	Skin _____	WNL
Oropharynx _____	WNL	Hernia _____	WNL
Neck _____	WNL	Spine _____	WNL
Heart _____	WNL	Joints _____	WNL
Lungs _____	WNL	Extremities _____	WNL
Abdomen _____	WNL	Other _____	WNL
Genitourinary _____	WNL		
Musculoskeletal _____	WNL		

Student may participate in sports: Yes _____ No _____ Deferred: _____

Restrictions/Limitations: _____

Please explain abnormal findings, including problems related to growth, development, or nutrition:

Please indicate any further diagnostic tests suggested: _____

___ Recommended for Adaptive Physical Education: _____

___ Refer to the Committee on Special Education (CSE) for a speech evaluation and recommended speech services.

Date: _____ Physician's Signature _____ Phone: _____

Sports-Reviewed by School Physician Signature _____ Date: _____