Key School
Est. 1966

2021-2022
Key School
Yearly Physical Examination

Student Name: _____ Male☐ Female☐ DOB _____

Date of Exam: _____ Ht: _____ Wt: _____ B/P: _____ Pulse: _____

Grade 2021-22: _____ Medication Allergies: _____

Physical exam to be completed by a licensed practitioner (MD, DO, PA, or APRN)

	Normal	Describe Abnormal		Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
Heart			Arms/Hands		
Lungs			Hips		
Abdomen			Knees		
Skin			Feet/Ankles		
Past medical history of:					

-Vision and Hearing Screenings: required for grades PK, K, 1, 3, 5, and 7 *AND* all <u>new</u> students to the school.
-Spinal screening: required for all girls ages 10 and 12, boys age 13 or 14.

Vision Screening			**Hearing Screening**			**Spinal Screening**	
Type of chart or device:			Type of device:			☐ No abnormality	
With glasses:	Right 20/	Left 20/	R 1000 Hz	R 2000 Hz	R 4000 Hz	☐ Abnormality:	
Without glasses:	Right 20/	Left 20/	L 1000 Hz	L 2000 Hz	L 4000 Hz	Mild Moderate Marked	
Pass or Fail			Pass or Fail			Currently being treated?	
Referral made?			Referral made?			Referral made?	

-Acanthosis Nigricans screening: required for grades 1, 3, 5, and 7.

Acanthosis Nigricans	Referral needed? Yes or No? If YES, need Ht, Wt, BP, and calculate BMI	Ht: Wt: BP (sitting, R arm): BMI:
☐ Pass ☐ Fail		

Health Conditions:

Allergies ☐None ☐Yes (circle one): Seasonal Environmental Contact

Asthma ☐No ☐Yes* (circle one): Intermittent Mild Moderate Severe Exercise Induced Cold induced

Diabetes ☐No ☐Yes* (circle one): Type I Type II

Food Allergy ☐None ☐Yes* (please indicate food): _____

Insect sting ☐No ☐Yes* (please specify): _____

Migraines ☐ No ☐ Yes*(please indicate type of migraine): _____

Seizures ☐No ☐Yes* (please indicate type of seizure): _____

Action Plan REQUIRED for all Yes answers* Exception: seasonal, environmental, contact allergies.

Physical Activity:

This student:
- ☐ **MAY** participate fully in school program/PE
- ☐ **MAY NOT** participate in school program/PE
- ☐ Has **RESTRICTIONS** and a detailed note has been attached, or submitted, to the Key School nurse.

Medications:

Please complete the Medication Administration Form for medications to be administered by the school nurse during the school day.

Physician:

I hereby certify that I have examined this student.

_____

Signature of Licensed Practitioner (MD, DO, PA or APRN) **Date Signed** **Printed Name and Phone Number**

Important Immunization Information for Parents:

Immunizations *must* be current *before the first day of school*. All new students, a current immunization record must be submitted to the school nurse before the first day of school. If immunizations have been updated within the last 12 months, a physician's verification is required and a copy of the official immunization record must be submitted to the school nurse for student's records. For those that choose to be exempt from immunizations, Affidavit of Exemption from Immunizations must be current and submitted before the student's first day of school. ***NOTE TO INCOMING 7th GRADERS:*** make sure to get your Tdap/Td (if at least 5 years have passed since the last dose of tetanus-containing vaccine) and Meningococcal (MCV4) immunization *before* the start of your 7th grade school year. Submit proof of these immunizations to the school nurse on or before the first day of school.