



2022-2023

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 new 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:			<input type="checkbox"/> No abnormality <input type="checkbox"/> Abnormality: Mild Moderate Marked		
With glasses:	Right 20/	Left 20/	R 1000 Hz	R 2000 Hz	R 4000 Hz			
Without glasses:	Right 20/	Left 20/	L 1000 Hz	L 2000 Hz	L 4000 Hz			
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:
<input type="checkbox"/> Pass <input type="checkbox"/> 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.