

Mt Ararat High School
 73 Eagles Way.
 Topsham, Maine 04086
 Tel.: 729-2951 ext 264
 Fax: 725-0143

PHYSICAL EXAMINATION FORM

Name: _____ M/F _____ Birthdate: _____ Grade _____

Physical exams are required for students entering Kindergarten, grades 6 and 9

Height _____ Weight _____ BP _____ P _____ Visual acuity R _____ L _____
 Hearing R _____ db L _____ db

Yes	No		Yes	No	
___	___	frequent headaches	___	___	toileting problem
___	___	dizziness/fainting	___	___	behavior/emotional problem
___	___	seizures	___	___	physical limitation
___	___	vision problem	___	___	scoliosis
___	___	hearing problem	___	___	heart disease
___	___	asthma/chronic cough	___	___	chronic illness
___	___	allergy	___	___	learning problem
___	___	frequent abdominal pain	___	___	special diet needs
___	___	diabetes	___	___	dental problem

Lab dates and results: TB Test _____ Lead Screening: _____ Urine _____ Hgb/Hct _____.

PROBLEM LIST

PLAN (meds, services, follow-up)

1. _____
 2. _____

IMMUNIZATIONS:

(Exact dates MONTH/DAY/YEAR are required for the following)

DPT	OPV/IPV	MMR	HIB	HBV
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

TD/dt _____ **Varicella** _____ **OTHER** _____

Student may participate in a full school program including a vigorous physical educations program and interscholastic athletics. (Specify limits if needed)

Physician (Printed Name) _____ Physician Signature: _____
 Date of Exam: _____