

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.*

*Robert Malito, Ph.D.  
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**

**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.

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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

YES	NO

**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