



RSU No. 5 Durham - Freeport - Pownal
STUDENT PHYSICAL & ATHLETIC EXAM
 For Students Entering PreK K 3rd 6th 9th 11th & all Transfer Students
To the Health Care Provider: Please Complete and Sign
 (Physician, Osteopath, Nurse Practitioner, Certified Nurse-Midwife or Physician Assistant)



Student's Name _____

DOB _____

GRADE _____

IMMUNIZATIONS

Please attach a complete Immunization Record. Is this student's record in ImmPact? Yes No

Student has a documented history of Chickenpox Disease? No Yes _____ Last Tetanus? _____
Date Date

Medical Exemption: This student has not received immunizations for medical reasons. (*Specify immunizations*) _____

Permanent Temporary (*Specify plan for immunization*) _____

MEDICATION at Home			MEDICATION at School			
This student is on long-term medication <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: _____ _____ _____			Medication	Dose	Time	Frequency
B/P	Pulse	This student has the knowledge and skill to carry and self-administer this medication. <input type="checkbox"/> Yes <input type="checkbox"/> No				
HT	BMI					

HEALTH NEEDS IN SCHOOL

EMERGENCY CONDITIONS (PLEASE attach an ACTION PLAN for the following conditions)

Anaphylaxis (Food /Sting Allergy) Cardiac Asthma Diabetes Seizure Other

Comments / recommendations / additional information _____

HEALTH CONCERNS (*explain below*)

Chronic Disease Physical Dysfunction Hearing Vision Behavioral/Social/Emotional Speech/Language

Allergies / Sensitivities / Intolerances _____

History of Concussion (If yes, provide dates) _____

PARTICIPATION

Student *may participate* fully in the school activities including physical education, sports, and co-curricular.

Student *may not participate* fully in the school program and has the following restriction/adaptation (*specify*): _____

Student's most recent PHYSICAL EXAM was done on: ____/____/____ (Date)

Signature of Health Care Provider _____

Name/Group Practice (Please Print) _____

Phone _____

Date _____