CHAMPLAIN VALLEY EDUCATIONAL SERVICES

P.O.Box 455 Plattsburgh, NY 12901
561-0100 Health Office ext. 314, 315, 392, 455

PHYSICAL EXAMINATION FORM

Student Name: _____ DOB: _____ Exam Date: _____

Weight: ____ Height: ____ BMI: _____ BP: _____ Pulse: _____ Vision: _____ Hearing: _____

Findings:	NORMAL	ABNORMAL	COMMENTS
Eyes			
Ears			
Nose			
Tonsils			
Teeth			
Thyroid			
Lymph Nodes			
Heart			
Lungs			
Abdomen			
Hernia			
Genito-urinary			
Musculo-skeletal			
Scoliosis Screen			
Feet			
Skin			
Nervous System			
Speech			
Nutrition			

Recommendations regarding school activities: _____

Referrals: _____

Chronic Illness: _____

Medications: _____

_____

Diagnosis: _____

Lab/Test Results (Lead level): _____

Immunizations Given: _____

_____ _____

(Physician Signature) **Please Print Physician Name**

_____

ADDRESS