SARATOGA CENTRAL CATHOLIC SCHOOL
247 Broadway, Saratoga Springs, NY 12866
Phone (518) 587-7070 • Fax (518) 587-0678

SARATOGA SPRINGS CITY SCHOOL DISTRICT

REPORT OF PHYSICAL EXAMINATION BY FAMILY PROVIDER

NAME: ______________________________ DATE OF BIRTH: ______________

SCHOOL: ________________________________ GRADE: ________________

Gender: ( ) Male ( ) Female

MEDICAL HISTORY:

Significant disease: ____ YES ____ NO
Surgeries: ____ YES ____ NO
Hospitalizations: ____ YES ____ NO
Allergies: ____ YES ____ NO

COMMENTS/DATES: __________
____
____
____
____

DATE OF EXAM: ______________ (Valid for one year from Date of Exam)

Height: ___________ Weight: __________
Blood Pressure: _________ Heart Rate: ______
Far Vision: R ___________ L ____________
Hearing: R ________db L __________db

Body Mass Index: ______________

Weight Status Category (BMI Percentile)
( ) less than 5th ( ) 5th through 49th
( ) 50th through 84th ( ) 85th through 94th
( ) 95th through 98th ( ) 99th and higher

Eyes: ___________________________
Ears: ___________________________
Nose: ___________________________
Tonsils: _________________________
Teeth: __________________________
Lymph Nodes: ____________________
Abdomen: ________________________
SCOLIOSIS: _______ YES _______ NO

Genito-Urinary: ___________________
Tanner: I. II. III. IV. V.
Thyroid: _________________________
Orthopedic: _______________________
Posture: _________________________
Feet: ____________________________
Nervous System: ___________________

IMMUNIZATION(S) GIVEN TODAY: ______________________________

Immunization record attached: ______ YES ______NO

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( ) Free from contagions & physically qualified for all physical education, sports, playground, work & school activities **OR**:

( ) Restrictions: ____

Special health needs: ___YES ___NO (comments) ______________________

Providers Signature: ______________________________ Date: __________

Providers Name Printed or office stamp: ___________________________