



'IOLANI SCHOOL

YEARLY PHYSICAL EXAMINATION FORM

STUDENT NAME DATE OF BIRTH MALE FEMALE
 EXAM PERFORMED ON: Height _____ Weight _____ B/P _____ / _____ Pulse _____

Physical Exam TO BE COMPLETED BY A U.S. LICENSED PRACTITIONER (MD,DO,PA or APRN)

	Normal	Describe Abnormal	Normal	Describe Abnormal
Neurologic			Neck	
HEENT			Shoulders	
Heart			Arms/Hands	
Lungs			Hips	
Abdomen			Knees	
Skin			Feet/Ankles	
Past medical hx of:				

Vision Screening

Type: Right Left
 With glasses 20/ 20/
 Without glasses 20/ 20/
 Referral made Not Done

Auditory Screening

Type: Right Left
Pass Pass
Fail Fail
 Referral made Not Done

Postural

No spinal abnormality
 Spinal abnormality:
Mild Moderate Marked
 Referral made Not Done

Health Conditions:

Allergies None Life Threatening*(action plan completed) Non-Life Threatening _____
 Asthma No Yes*(circle one): Intermittent Mild Moderate Severe Exercise Induced Cold Induced
 Diabetes No Yes*(circle one): Type I Type II
 Seizures No Yes*(circle one): Epileptic Rolandic Other _____
 *Action plan REQUIRED

Physical Activity:

This student: **MAY participate fully in school program/PE/athletics and competitive sports**
 MAY NOT participate in school program/PE/athletics and competitive sports
 Has **RESTRICTIONS** and a detailed note has been attached or previously submitted to the 'Iolani School Infirmary

Medications:

Daily: _____ PRN: _____
 >Please complete Medication Administration Form for all medications to be administered by school nurse during the school day

PHYSICIAN: I hereby certify that I have examined this student.

Signature of U.S. Licensed Practitioner (MD,DO,PA or APRN) Date Signed Printed/Stamped Name and Phone Number