

PHYSICAL EXAMINATIONS OF STUDENTS

Name _____ Birth Date _____

School _____

Grade _____

PHYSICAL EXAMINATION (To be completed by licensed health care provider. Other forms may be used at the discretion of the school nurse, as long as the alternate form contains all information on JLCA-F).

DATE: _____ Height _____ Weight _____

Remarks or special instructions: Previous Diseases and Operations: _____

Is this child capable of carrying a full program of schoolwork including gymnastics and athletics? Yes _____ No _____

Must the school program be modified to meet the needs of this child? Yes ___ No ___

By restriction of use of stairs: Yes ___ No ___

By special seating accommodations? Yes ___ No ___

Other (specify) Yes ___ No ___

Completed immunizations: Yes ___ No ___ If no, please explain: _____

Date of examination

Examining Health Care Provider

Proposed: 04/17/2023

Adopted: 06/05/2023