COCHRANE-FOUNTAIN CITY SCHOOL DISTRICT
HEALTH EXAMINATION REPORT

Student Name _____DOB_____Gender _____

Parent/Guardian Name _____Phone _____

Address _____

Physical Exam:

Height _____ Percentile _____ Weight _____ Percentile _____

Vision R _____Left_____ Normal_____Abnormal_____

Hearing R_____Left_____ Normal_____Abnormal_____

Blood Pressure _____ Normal_____Abnormal_____

Pulse _____ Normal_____Abnormal_____

Comments or explanation of abnormal findings:

_____

Check if abnormal:

Head	_____	Lungs	_____	Extremities	_____
Eyes	_____	Heart	_____	Skin	_____
Ears	_____	Abdomen	_____	Metabolic	_____
Nose	_____	Genitalia	_____	CNS	_____
Throat	_____	Muscle Tone	_____		
Neck	_____	Coordination	_____	NO Abnormal Findings	_____
Chest	_____	Back	_____		

Comments or explanation of abnormal findings:

_____

Lab Results (Optional):

Hemoglobin _____ Normal_____Abnormal_____

Urinalysis _____ Normal_____Abnormal_____

Other Lab _____ Normal_____Abnormal_____

Comments or explanation of abnormal findings:

_____

Are medications at school necessary?	Yes _____	No _____
Are special needs treatments at school necessary?	Yes _____	No _____
Is occupational therapy advised?	Yes _____	No _____
Is physical therapy advised?	Yes _____	No _____
Is adaptive physical education advised?	Yes _____	No _____
Is student capable of a complete school program load?	Yes _____	No _____
Is special seating required?	Yes _____	No _____
Is there evidence of chronic health conditions	Yes _____	No _____
Is there evidence of physical defects?	Yes _____	No _____
Is there evidence of to suggest a learning disability?	Yes _____	No _____
Is there evidence to suggest cognitive deficit or delay?	Yes _____	No _____
Is there evidence of significant emotional upset?	Yes _____	No _____

Comments or explanations:

_____

Classification of Physical Activity:

Unrestricted activity _____

Slightly modified activity-under observation _____

Restricted _____

No physical education _____

Explain/define any restrictions or modifications required: _____

_____

_____

Any additional remarks/recommendations/orders for school. Include need for medical, dental, psychiatric, or specialized care.

_____

_____

_____

_____

Signature of Examining Physician _____

Address _____

Phone _____ Date _____