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