

**SAMPLE**  
**Physical Examination**  
*(To be completed by a Physician)*

NOTE TO PHYSICIAN: New Mexico Standards for Special Education require that certain special education students receive a current physical examination and recommendations from a medical doctor, inclusive of a medical diagnosis and etiology for all physical and/or health impairments, prognosis, physical limitations, medications and description of prosthetic devices. We thank you for your cooperation in completing all pages of this form in full.

Student Name: _____ DOB: _____ Date of Exam: _____
School Name: _____ Grade: _____ Student Number: _____
Primary Medical Diagnosis/Problem List: _____ _____
Etiology (ies): _____
Prognosis: _____
Ht: _____ Wt: _____ FOC: _____ B/P: _____

1. Are immunizations current?  Yes  No

Date of last DPT: \_\_\_\_\_ OPV: \_\_\_\_\_ MMR: \_\_\_\_\_

Immunization exemption required? \_\_\_\_\_ Reason: \_\_\_\_\_

2. Are there any abnormalities in physical, mental, emotional, motor or speech development?  Yes  No

Circle those that apply and explain: \_\_\_\_\_  
\_\_\_\_\_

3. Does this child have any physical or health impairment, syndrome, chronic illness or acute health condition which might limit strength, vitality or alertness or require adaptation of the educational program?  Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Current Medication: Is child on any medication?  Yes  No If yes, list and include dosage, frequency, etc:

\_\_\_\_\_  
\_\_\_\_\_

5. Allergies: Please list any known allergies or allergic reactions: \_\_\_\_\_  
\_\_\_\_\_

6. Nutrition: Please explain any concerns about nutritional status or feeding problems: \_\_\_\_\_

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7. Review of Systems:

**Eyes**  NORMAL  ABNORMAL  
Visual Acuity (if known) R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Glasses:  Yes  No

**Ear**  
Myringotomies  R  L Date tubes placed: \_\_\_\_\_  
Hearing Aids  R  L Other: \_\_\_\_\_

**Teeth**  NORMAL

**Skin, Lymphatics**  NORMAL

**Chest, Lungs**  NORMAL

**Heart**  NORMAL

**Abdomen**  NORMAL  
Hernia  Yes  No

**Genitalia**  NORMAL

**Musculoskeletal**  NORMAL

**Neurological**  NORMAL

Does child have a **shunt**?  Yes  No

Does child have a **seizure disorder**?  Yes  No

If yes, please complete the following:

A. Prodromal symptoms: \_\_\_\_\_

B. Type of Seizure: \_\_\_\_\_

C. Usual severity: \_\_\_\_\_

D. How well are seizures controlled? \_\_\_\_\_

8. Does the child require any therapeutic or prosthetic devices?  Yes  No If yes, please explain:

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9. Will any nursing therapeutic procedures/treatments be required at school? (e.g. catheterization, suction, tube feeding, etc.)

Yes No If yes, explain and complete a Specialized Health Service Form:

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10. Do you have any suggestions to be considered regarding management of health or safety needs at school? (e.g. physical or emotional considerations, limitation of activity, etc.) Yes No

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11. Would you approve an evaluation and/or therapy by a physical or occupational therapist, if indicated? Yes No

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12. If applicable, can this child participate in an adapted physical education program, including closely supervised swimming instruction? Yes No Comments/Restrictions:

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13. If age appropriate, may student participate in Special Olympics this year? Yes No Comments:

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14. If Down Syndrome, has child been evaluated for atlantoaxial dislocation? Yes No

Results: Positive Negative Date of X-ray evaluation: \_\_\_\_\_

15. Are there any observations related to this child's medical condition which you would like to have reported to you?

Yes No If yes, please explain:

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16. Will you be continuing medical management of this child? Yes No

Signature of Physician: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_