



# RAVENSCROFT

FOUNDED 1862

7409 Falls of Neuse Road  
Raleigh, NC 27615

2010-2011

## PHYSICAL EXAMINATION FORM

### FOR OFFICE USE ONLY:

Name: \_\_\_\_\_

Class \_\_\_\_\_ Entered:

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

**NOTE TO PHYSICIAN:** Ravenscroft requires a completed Physical Examination Form for all entering Pre Kindergarten and Kindergarten students, all new students, and students re-enrolling in Grades 6 & 9. All participants in the athletic program must have a physical which will be good for all athletic activities for 13 months from the date of exam.

### To be completed by Parents:

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Entering Grade \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Is your child planning on participating in athletics during the 2010-2011 school year?  Yes  No

\*If yes, please submit a copy of this physical form to the Ravenscroft Athletic Office.

### PREVIOUS MEDICAL HISTORY OF STUDENT: To be completed by Physician:

Does the student have any drug allergies? \_\_\_\_\_ If yes, please specify: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

To your knowledge, has this student been treated for, or does this student have, any emotional or psychological problems? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

Does the student have disorders such as Diabetes, Epilepsy, Heart Disease or past serious injuries or surgery? \_\_\_\_\_

Specify: \_\_\_\_\_

Date of Exam \_\_\_\_\_

### PHYSICAL EXAMINATION

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ B.P: \_\_\_\_\_ Pulse: \_\_\_\_\_ Hearing: Rt: \_\_\_\_\_ Lt: \_\_\_\_\_

Vision: Rt: \_\_\_\_\_ Lt: \_\_\_\_\_ Heart: \_\_\_\_\_ Lungs: \_\_\_\_\_ Abdomen: \_\_\_\_\_ Hernia: \_\_\_\_\_

Posture: \_\_\_\_\_ Urinalysis: \_\_\_\_\_ Hgb. Or Hct: \_\_\_\_\_ Disabilities: \_\_\_\_\_ Limitations: \_\_\_\_\_

### IMMUNIZATIONS (Indicate date of each immunization:

VACCINE (circle one)	Date	Date	Date	Date	Date	VACCINE	Date	Date	Date
DTP/DtaP/DT						Hepatitis A			
Hib						Gardasil			
IPV/OPV						Meningitis Vaccine			
Td						Tdap			
MMR						Varicella			
Hepatitis B									

**\*\*\*MEDICAL EXEMPTION:** If any required immunization is contraindicated, please complete the "Physician's Request for Medical Exemption" Form and attach to Physical Form.

Tuberculin test: (if indicated) \_\_\_\_\_. If Positive, X-ray and give date and results: \_\_\_\_\_

### ACTIVITY

Is this student able to participate in Physical Education? \_\_\_\_\_

If not, please explain: \_\_\_\_\_

May this student compete in all athletics? \_\_\_\_\_ If not, which of the following should be omitted:

Soccer: \_\_\_\_\_ Football: \_\_\_\_\_ Lacrosse: \_\_\_\_\_ Swimming: \_\_\_\_\_ Softball: \_\_\_\_\_ Tennis: \_\_\_\_\_ Track: \_\_\_\_\_

Basketball: \_\_\_\_\_ Golf: \_\_\_\_\_ Baseball: \_\_\_\_\_ Gymnastics: \_\_\_\_\_ Volleyball: \_\_\_\_\_ Cross Country: \_\_\_\_\_

Wrestling: \_\_\_\_\_ Cheerleading: \_\_\_\_\_ Comments: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Physician's Name (Print): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_