

# GREATER JOHNSTOWN SCHOOL DISTRICT

## JOHNSTOWN HIGH SCHOOL

2 Wright Drive

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John S. Whelan  
Superintendent of Schools

Warren Street School  
Johnstown NY 12095  
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Katherine A. Sullivan  
Assistant Superintendent  
For Curriculum & Instruction

## PHYSICAL EXAMINATION RECORD

Name of Student \_\_\_\_\_

Grade \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Nutrition \_\_\_\_\_

Genito-Urinary \_\_\_\_\_

Tonsils \_\_\_\_\_

Thyroid \_\_\_\_\_

Heart \_\_\_\_\_

Teeth \_\_\_\_\_

Lungs \_\_\_\_\_

Nose/Sinuses \_\_\_\_\_

Hernia \_\_\_\_\_

Lymph Nodes \_\_\_\_\_

Nervous System \_\_\_\_\_

Orthopedic \_\_\_\_\_

Skin \_\_\_\_\_

Spine \_\_\_\_\_

Feet \_\_\_\_\_

Eyes: Right \_\_\_\_\_ Left \_\_\_\_\_ without correction

Right \_\_\_\_\_ Left \_\_\_\_\_ with correction

Ears: Right \_\_\_\_\_ Left \_\_\_\_\_

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

Medications: \_\_\_\_\_

Immunizations received during past year (please include dates given): \_\_\_\_\_

Recommendations for follow-up and/or modification of school program including physical activity restrictions: \_\_\_\_\_

Is this student medically cleared to participate in sports? YES \_\_\_\_\_ NO \_\_\_\_\_

DATE OF EXAM: \_\_\_\_\_

SIGNATURE OF HEALTH CARE PROVIDER: \_\_\_\_\_

Reviewed by Nurse (date & title): \_\_\_\_\_