Blue Mountain Academy

Physical Examination Form

(To be completed by a Health Care Provider)

Must be completed within 12 months prior to student's first day of school.

______________________________________ ______________ __________
Student's Name (Print) Birth Date Grade

____ ______________
Street Address City State Zip Home Phone

Allergies: ____

Significant Illness, Accidents, Operations, Congenital Defects, Family History, Etc.:

____

____

Height: __________ Weight ___________ BMI ___________ Vision Exam ☐ Check of corrective lenses

Pulse: ___________ Resp: _____________ B/P ___________ Right Eye ____________ Left Eye _____________

PHYSICAL	NORMAL	ABNORMAL	FOLLOW-UP/ COMMENTS
SKIN			
EYES			
EARS			
NOSE			
THROAT			
MOUTH			
CARDIOVASCULAR			
RESPIRATORY			
GLANDS			
GASTROINTESTINAL			
GENITOURINARY			
NEUROLOGICAL			
MUSCULAR SKELETAL			
SCOLIOSIS SCREENING			
NUTRITIONAL STATUS			
MENTAL STATUS			

I certify that I have examined this student on (date) ____________________. On the basis of this examination, I have found no reason that would make it medically inadvisable for this student to participate in supervised athletic activities.

__________________________________ __________________________________
Health Care Provider's Signature Health Care Provider's Name (Print)

____ ________________
Office Address City State Zip Office Phone

Blue Mountain Academy

Immunization Records

____ _________________ __________

Student's Name (Print) Birth Date Grade

☐ Medical Exemption (The physical condition of the student listed above is such that immunization would endanger life or health)

☐ Religious Exemption (Include in writing a strong moral or ethical conviction related to a religious belief by parent/guardian)

Required immunizations prior to the first day of school ĭ

Immunization	Date	Date	Date	Date	Date
	1st Dose	2nd Dose	3rd Dose	4th Dose	Booster
Diphtheria, Pertussis & Tetanus	ĭ	ĭ	ĭ	ĭ	ĭ
Diphtheria, Pertussis & Tetanus	Booster	Booster	Booster		
Oral Polio	ĭ	ĭ	ĭ	ĭ	
Hepatitis B	ĭ	ĭ	ĭ		
Measles – Mumps – Rubella	ĭ	ĭ			
Titer:					
Varicella	ĭ	ĭ			
Date of the Disease:					
Meningococcus Vaccine					
TB Screening	Date	Negative	Positive	Result (mm)	
Other:					

___________________________ __________________________ _______________

Health Care Provider's Signature Health Care Provider's Name (Print) Date