SA

STUDENT HEALTH FORMS

Suffield Academy Health Center 185 North Main Street Suffield, Connecticut 06078
Phone: 860-386-4503 | Fax: 860-386-4544 | healthcenter@suffieldacademy.org

STUDENT NAME

FIRST NAME _____ LAST NAME _____ DOB _____

PHYSICAL EXAMINATION RECORD

EXAM DATE _____ **ALLERGIES** _____

All students must have a physical exam that is current (within 12 months) at all times to participate in school programs and activities.

Blood pressure _____ Pulse _____

Height (inches) _____ Weight (pounds) _____

Urinalysis _____

sugar _____

albumin _____

micro _____

Hemoglobin or hematocrit _____

Asthma [If yes, please provide a copy of Asthma Action Plan]

❑ No

❑ Yes ❑ Intermittent ❑ Mild Persistent

❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise Induced

Anaphalaxis [If yes to food, please provide a copy of Food Allergy Action Plan]

❑ No

❑ Yes ❑ Food ❑ Insects ❑ Latex ❑ Unknown Source

History of Anaphalaxis ❑ No ❑ Yes

Epipen Required ❑ No ❑ Yes

Prior medical/psychological conditions _____

Previous musculoskeletal injuries _____

Current medical/psychological conditions _____

Psychotherapy or counseling history _____

Review of Systems Describe fully. Use additional sheet if needed.

	WNL	ABNL
Head, ears, nose, throat		
Hearing		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		
Any other conditions		

Medications to be continued at school (please list dose and schedule for each medication)

_____

_____

_____

For returning students only: please list immunizations since last physical.

_____

_____

_____

My examination finds the student named above to be in good health, free from contagion, and physically and emotionally qualified for a full program of study and sports.

❑ Yes ❑ No **If no, please explain:** _____

Print or type name and address of examining physician: _____

Phone Number Street City State Country Zip Code

Physician's Signature (required) Date

2020-2021