Report of Physical Examination

This form should be submitted directly to: Commonwealth Charter Academy, 1 Innovation Way, Harrisburg, PA 17110
Or send it by fax to 717-307-3320.

Student Information

☐ M ☐ F

Last Name | First Name | Middle Initial | Grade | Date of Birth | Gender

Student's Street Address | Apartment/Unit #

City | State | ZIP Code | Home Phone | Other Phone

Allergies	☐ Yes ☐ No	Gastrointestinal Disorder	☐ Yes ☐ No	Respiratory Illness	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hearing Disorder	☐ Yes ☐ No	Seizure Disorder	☐ Yes ☐ No
Cardiac	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	Skin Disorder	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Neuromuscular Disorder	☐ Yes ☐ No	Vision Deficiency	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Orthopedic Condition	☐ Yes ☐ No	Other:_____	☐ Yes ☐ No

Please explain any "Yes" answer(s) in detail:

	HEIGHT:		**WEIGHT:**		
BMI	☐ N ☐ A	Nose & Throat	☐ N ☐ A	Neuromuscular	☐ N ☐ A
Pulse	☐ N ☐ A	Teeth & Gingiva	☐ N ☐ A	Skeletal	☐ N ☐ A
Blood Pressure	☐ N ☐ A	Lymph Glands	☐ N ☐ A	Scoliosis	☐ N ☐ A
Nutrition	☐ N ☐ A	Heart (murmurs?)	☐ N ☐ A	Emotional Status	☐ N ☐ A
Skin, Hair, Scalp	☐ N ☐ A	Lungs	☐ N ☐ A	Other:_____	☐ N ☐ A
Eyes	☐ N ☐ A	Abdomen	☐ N ☐ A	N = Normal A = Abnormal	
Ears	☐ N ☐ A	Genitourinary	☐ N ☐ A		

Please give significant details of any abnormalities noted, including: serious illness; diseases; operations; accidents; disabilities; or physical, social, or emotional development issues: _____

Are there any special medical problems or chronic diseases which require restriction of activity, medication, or which might affect this student's education? If so, please specify: _____

Did student pass hearing screens at 25dB, 250, 500, 1000, 2000, 4000, 8000 levels in both ears? ☐ Yes ☐ No ☐ Not Done

Does student wear glasses? ☐ Yes ☐ No Distance vision: _____ (Right) _____ (Left) Near vision: _____ (Right) _____ (Left)

Depth discrimination test: ☐ Pass ☐ Fail Color discrimination test: ☐ Pass ☐ Fail

Did student need any referrals for hearing, vision, and/or other significant problems? If so, please list: _____

Is student up-to-date on immunizations? (Please attach a current copy of immunization records.) ☐ Yes ☐ No

Name of Examiner (Please print) | Signature of Examiner | Date of Exam

Office's Address | Office's Phone