



PILLAR SCHOOLS
2024-2025 SCHOOL YEAR

Physical Examination Report

Date of Exam: _____

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

PHYSICAL EXAMINATION:

Diagnosis: _____ BP _____

Head Cir. _____ Height _____ Weight _____ TPR _____

ALLERGIES: _____

VISION: _____

Suggested Follow Up (include Physician name and Contact Info): _____

ORAL: Any abnormality of teeth, gums, tongue, palate, etc.: _____

Suggested Follow Up (include Physician name and Contact Info): _____

Auditory: _____

Auditory evoked potential (if applicable): _____

Suggested Follow Up (include Physician name and Contact Info): _____

HEENT: _____ NECK: _____

CHEST/BREAST: _____

LUNGS: _____

Asthma (If yes, include Asthma Action Plan): _____

ABDOMEN: _____

Any abnormalities? _____

CARDIAC STATUS: _____

Abnormalities/Results: _____

Suggested Follow Up (include Physician name and Contact Info): _____

Echo Date Done (If applicable): _____

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Student Name: _____ Date of Birth: _____

Any Limitations? (Explain): _____

Suggested Follow Up (include Physician name and Contact Info): _____

URINARY TRACT AND BOWL INFECTIONS:

Abnormalities: _____

Suggested Follow Up (include Physician name and Contact Info): _____

MUSCULOSKELETAL SYSTEM:

Abnormalities: _____

Suggested Follow Up (include Physician name and Contact Info): _____

NEUROLOGICAL:

Abnormalities: _____

Seizure History: _____

Suggested Follow Up (include Physician name and Contact Info): _____

SHUNT: Date inserted: _____ Last Revision: _____

SURGICAL PROCEDURES:

1. Describe: _____

Date Done: _____ Where performed: _____

2. Describe: _____

Date Done: _____ Where performed: _____

3. Describe: _____

Date Done: _____ Where performed: _____

IMMUNIZATION STATUS

***Doctor's office, please attach immunization printout/record.

***Medical Exemption- *include documentation from physician.*

***Religious Exemption- *include parent statement.*

RESTRICTIONS (please note any restrictions or precautions for physical activity): _____

Physicians Name: _____ Date: _____

Physicians Signature: _____ Date: _____

Stamp: