PENNWOOD CYBER CHARTER SCHOOL

Pennwood Cyber Report of Physical Examination Form

Form Facts

What: This form may be used to obtain physical examination information for a student from his or her health care provider if no other print out or record is available from the student's health care provider.
Who: Families who are enrolling students are requested to submit a report of physical examination from a health care provider.
Why: A valid report of physical examination is requested for each student in order to comply with state regulations.
Where: Submit enrollment documents to **Pennwood Cyber Charter School** by: Fax: 800-887-6590
Mail: 509 S. Exeter St, Suite 202, Baltimore, MD 21202

Student Information

Name: _____ Gender: ☐ Male ☐ Female

Current Grade:_____ Date of Birth:_____ Phone Number: _____

Street Address: _____

City: _____ State:_____ ZIP Code: _____

Physical Examination Results

This section must be completed by a health care provider (physician, health official, school nurse, or designee of one of these providers).

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: _____

N= Normal A= Abnormal Height : _____ Weight: _____ (**Required for all students in grades K-12**)

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

_____

Required for all students in grades K, 1, 2, 3, 7, and 11:
Did student pass hearing screens at 25dB, 250, 500, 1000, 2000, 4000, 8000 levels in both ears? ☐ Yes ☐ No ☐ Not Done

Required screening for all students in grades K-12:
Does student wear glasses? ☐ Yes ☐ No Distance vision: Right _____ Left_____ Near vision: Right _____Left _____

Required for 1st grade students only:
Depth discrimination test: ☐ Pass ☐ Fail Color discrimination test: ☐ Pass ☐ Fail

Required for all students in grades K-12:
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

Signature of Health Care Provider

By signing below, I certify that the above information is true to the best of my knowledge.

Health Care Provider's Name	Health Care Provider's Signature	Date	Phone

Street Address	City	State	ZIP Code

