



# Reach Cyber Report of Physical Examination



ALL students in Kindergarten, 6th and 11th grades are required by Pennsylvania School Health laws to have a physical exam completed and on file with their school.

Documents can be submitted to Reach Cyber Charter School Nursing Department by email to: Reach\_nurses@reachcyber.org or fax to 1-717-483-2804

## Student Information

Name(First,Middle,Last): \_\_\_\_\_

Current Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Physical Exam Results:

**Exam Date:** \_\_\_\_\_

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

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuromuscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**N= Normal A= Abnormal**

BMI	<input type="checkbox"/> N <input type="checkbox"/> A	Ears	<input type="checkbox"/> N <input type="checkbox"/> A	Abdomen	<input type="checkbox"/> N <input type="checkbox"/> A
Pulse	<input type="checkbox"/> N <input type="checkbox"/> A	Nose & Throat	<input type="checkbox"/> N <input type="checkbox"/> A	Genitourinary	<input type="checkbox"/> N <input type="checkbox"/> A
Blood Pressure	<input type="checkbox"/> N <input type="checkbox"/> A	Teeth & Gingiva	<input type="checkbox"/> N <input type="checkbox"/> A	Neuromuscular	<input type="checkbox"/> N <input type="checkbox"/> A
Nutrition	<input type="checkbox"/> N <input type="checkbox"/> A	Lymph Glands	<input type="checkbox"/> N <input type="checkbox"/> A	Skeletal	<input type="checkbox"/> N <input type="checkbox"/> A
Skin, Hair, Scalp	<input type="checkbox"/> N <input type="checkbox"/> A	Heart (murmurs?)	<input type="checkbox"/> N <input type="checkbox"/> A	Scoliosis	<input type="checkbox"/> N <input type="checkbox"/> A
Eyes	<input type="checkbox"/> N <input type="checkbox"/> A	Lungs	<input type="checkbox"/> N <input type="checkbox"/> A	Emotional Status	<input type="checkbox"/> N <input type="checkbox"/> A
Other: _____					<input type="checkbox"/> N <input type="checkbox"/> 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: \_\_\_\_\_

Please list any medications the student is currently taking: \_\_\_\_\_

# State Mandated Health Screenings

All required sections must be completed by physician

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## 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: Vision Results: Pass Fail Not Done

Does student wear glasses?  Yes  No Distance vision: Right \_\_\_\_\_ Left \_\_\_\_\_ Near vision: Right \_\_\_\_\_ Left \_\_\_\_\_

## Required for 1<sup>st</sup> grade students only:

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

Required for all students in grades K-12: Height : \_\_\_\_\_ Weight: \_\_\_\_\_

## Required for all students in grade 6 & 7:

Scoliosis Screening: 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

## Signature of Health Care Provider

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

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Health Care Provider's Name	Health Care Provider's Signature	Date	Phone
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Street Address	City	State	ZIP Code
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