Indian Mountain School
life through service — Est. 1922

PHYSICAL EXAMINATION RECORD

To Be Completed by a Healthcare Provider

Name (Last,First) _____ DOB (mm/dd/yy)_____ Date of Physical_____

ALLERGIES (Drug/Food/Other) _____

Life Threatening ☐ Yes ☐ No ☐ EpiPen Prescribed ☐ Action Plan Attached

Height (inches)_____Weight (lbs.)_____ Blood Pressure:_____Pulse:_____Murmurs:_____

Date/Result of last eye exam:_____L _____R (Circle) Glasses Contact lenses Color blind?

TB Screening (Required for all international students from high-risk regions and any other high-risk students)

TB test: ☐ PPD ☐ IGRA (Quantiferon or TB Spot) TB test date:_____ TB test result:_____

Chest x-ray date:_____ Chest x-ray result:_____ Treatment:_____

☐ This student is NOT at high risk for TB

Please indicate any history of, or current diagnosis involving, the following systems:

	YES	No	Date	Notes:
Congenital anomalies				
Neurological				
Psychiatric				
Dermatologic				
Head/Neck				
Eyes				
Ears/Hearing				
Nose/Throat				
Respiratory				
Cardiovascular				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Metabolic/Endocrine				
Menarche/Age				
Any other condition				

CLEARANCE FOR PARTICIPATION

☐ Full participation in academics, athletics, extracurricular activities

☐ Limited participation, with the following restrictions: _____

_____ _____ _____

Signature of healthcare provider | Printed/stamped name of healthcare provider | Date

_____ _____ _____

Office phone number | Office fax | Provider email