HEALTH SERVICES
ST. FRANCIS OF ASSISI CATHOLIC SCHOOL

Name: ____________________________ Birthdate: ____________ Grade: _________

PHYSICAL EXAMINATION:

To be completed by health care provider approved to perform health assessments.

Height ___________ Weight ___________

Pulse ___________ Blood Pressure ___________ Other ___________

Code each item as follows: 0 = No significant finding 1 = Significant finding	Code	Description of Findings
General Appearance Integument Head - Neck EENT Oral - Dental Thorax Breasts Cardiovascular Abdomen Musculoskeletal Genitourinary Neurological		

Significant Assessment Findings:

Recommendations: (include referrals)

Follow Up:

___________ ____

Date *Signature of Licensed Physician or Nurse approved to perform health assessments*