

# GREATER JOHNSTOWN SCHOOL DISTRICT

## JOHNSTOWN HIGH SCHOOL

2 Wright Drive

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Superintendent of Schools

Jansen Avenue School  
Johnstown NY 12095  
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Katherine A. Sullivan  
Assistant Superintendent  
For Curriculum & Instruction

## PHYSICAL EXAMINATION RECORD

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Nutrition \_\_\_\_\_ Genito-Urinary \_\_\_\_\_

Tonsils \_\_\_\_\_

Thyroid \_\_\_\_\_ Heart \_\_\_\_\_

Teeth \_\_\_\_\_ Lungs \_\_\_\_\_

Nose/Sinuses \_\_\_\_\_ Hernia \_\_\_\_\_

Lymph Nodes \_\_\_\_\_ Nervous System \_\_\_\_\_

Orthopedic \_\_\_\_\_ Skin \_\_\_\_\_

Spine \_\_\_\_\_

Feet \_\_\_\_\_

Eyes: Right \_\_\_\_\_ Left \_\_\_\_\_ without correction

Right \_\_\_\_\_ Left \_\_\_\_\_ with correction

Ears: Right \_\_\_\_\_ Left \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Immunizations received during past year (please include dates given): \_\_\_\_\_

Recommendations for follow-up and/or modification of school program including physical activity restrictions: \_\_\_\_\_

Is this student medically cleared to participate in sports? YES \_\_\_\_\_ NO \_\_\_\_\_

DATE OF EXAM: \_\_\_\_\_

SIGNATURE OF HEALTH CARE PROVIDER: \_\_\_\_\_

Reviewed by Nurse (date & title): \_\_\_\_\_