PHYSICAL EXAMINATION FORM

This medical form must be completed by a licensed medical practitioner and submitted to YIS Admissions within 6 months of the exam date.

1: STUDENT INFORMATION

Student Name: (Last Name) _____ (First Name) _____ (Middle Name) _____

Date of Birth (YYYY/MM/DD): _____ **Gender:** □ Male □ Female

2: MEDICAL HISTORY & DIAGNOSED CONDITIONS

Life-Threatening Conditions:	□ None □ Anaphylaxis (Epinephrine prescribed) Specify allergen(s): _____ Triggers: □ Inhalation □ Contact □ Ingestion □ Severe Asthma (Requires inhaler/medication) □ Diabetes □ Other Condition: _____
Allergies:	□ None □ Yes (List all allergens): _____
Asthma:	□ None □ Active □ Exercise-Induced □ Past History □ Other Respiratory Condition: _____
Required: Parents of students with allergies/asthma must complete a supplementary YIS Health Questionnaire prior to enrollment.	
Gastrointestinal & Dietary Constraints:	□ None □ Celiac Disease □ Lactose Intolerance □ Food Intolerance: _____ □ Medical Dietary Restriction: _____ □ Other GI Condition: _____
Neurological, Developmental & Mental Health:	Seizures/Epilepsy: □ None □ Active □ History (Year: _____) Nervous System: □ None □ ADHD □ ADD □ Autism □ Migraines □ Developmental Disability □ Traumatic Brain Injury (Year: _____) □ Other Neurological Condition: _____ Mental/Behavioral: □ None □ Anxiety □ Sleep Disorder □ Depression □ Other: _____
Surgeries & Other Medical Conditions:	Other Conditions: □ None □ Yes: _____ Major Accidents/Surgeries: □ None □ Yes: _____

3: CLINICAL PHYSICAL EXAMINATION ASSESSMENT

SYSTEM / AREA	STATUS	SYSTEM / AREA	STATUS
Eyes / Vision (□ Glasses/Contacts Used)	□ Normal □ Abnormal: _____	**Ears / Hearing** (□ Hearing Aids Used)	□ Normal □ Abnormal: _____
Mouth / Teeth / Oral Cavity	□ Normal □ Abnormal: _____	**Neurological**	□ Normal □ Abnormal: _____
Nose / Throat	□ Normal □ Abnormal: _____	**Psychological / Behavioral**	□ Normal □ Abnormal: _____
Lymph Nodes	□ Normal □ Abnormal: _____	**Integumentary (Skin)**	□ Normal □ Abnormal: _____
Respiratory / Lungs	□ Normal □ Abnormal: _____	**Musculoskeletal** (Incl. Scoliosis)	□ Normal □ Abnormal: _____
Cardiovascular / Heart	□ Normal □ Abnormal: _____	**Nutritional Status**	□ Normal □ Abnormal: _____
Gastrointestinal	□ Normal □ Abnormal: _____	**Genitourinary**	□ Normal □ Abnormal: _____
Endocrine System	□ Normal □ Abnormal: _____	**Additional Clinical Observations**	□ Normal □ Abnormal: _____

4: MEDICATIONS & PHYSICAL CLEARANCE

Epinephrine Prescription:	□ Yes □ N/A
Home Medication Requirements:	□ No □ Yes: _____
School Medication Requirements:	□ No □ Yes: _____
Physical Education / Athletic Clearance:	□ Clear for full participation □ Activity Restricted (Details): _____
Immunization Compliance:	□ Fully up to date with required immunizations □ Incomplete (Details): _____
Most Recent DTaP/Td Booster Date (YYYY/MM/DD): _____	

Additional Remarks / Physician Notes:

_____

5: PHYSICIAN VERIFICATION & OFFICIAL STAMP

Physician Name (Printed): _____

Physician Signature: _____

Medical Facility & Address: _____

Contact Phone Number (with Country Code): _____

Date of Examination (YYYY/MM/DD): _____

OFFICIAL MEDICAL SEAL / CLINIC STAMP