SCHOOL ID: 468574

ST. LORENZO SCHOOL OF POLOMOLOK, INC.

PUROK SAN AGUSTIN, POLOMOLOK, SOUTH COTABATO 9504

(083) 878-4653 inquiry@slspi.edu.ph www.slspi.edu.ph

Student Physical Examination Form

Student Information

Full Name: _____ Grade: _____ Date of Birth: ____ / ____ / ____ Age: ____

Medical History (To Be Completed by Parent/Guardian) Please check any past or current condition(s):

Condition	Yes	No	If Yes, Please Explain
Asthma	[ ]	[ ]	_____
Allergies (food, medication, etc.)	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Seizure Disorder	[ ]	[ ]	_____
Heart Condition	[ ]	[ ]	_____
Vision or Hearing Problems	[ ]	[ ]	_____
Current Medications	[ ]	[ ]	_____
Surgeries or Hospitalizations	[ ]	[ ]	_____
Other Medical Conditions	[ ]	[ ]	_____

Physical Examination (To Be Completed by Physician)

System/Check	Findings/Results
Height: _____ cm/in	Weight: _____ kg/lb
BMI: _____	Blood Pressure: _____
Pulse: _____ bpm	Respiratory Rate: _____/min
Vision: Left ____ / Right ____	With Glasses? [ ] Yes [ ] No
Hearing: [ ] Normal [ ] Abnormal	If abnormal, explain: _____
Eyes	_____
ENT	_____
Cardiovascular	_____
Respiratory	_____
Abdomen	_____
Genitourinary	_____
Skin	_____
Neurological	_____
Musculoskeletal/Posture	_____

BLOOD TYPE ____

Physician's Clearance

Based on today's examination, this student is:

☐ Cleared for all school activities, including physical education and sports.

☐ Cleared with the following restrictions: _____

☐ NOT cleared for participation due to: _____

Additional Comments or Recommendations:

_____

_____

Physician/Healthcare Provider Information

Provider Name (Print): _____ Signature: _____

License Number: _____ Date of Exam: _____ / _____ / _____

Address: _____

Dental Examination (To Be Completed by Dentist)

Evaluation Area	Normal	Abnormal	Comments/Findings
Teeth (Cavities, Decay)	[ ]	[ ]	_____
Gums (Gingivitis, Bleeding)	[ ]	[ ]	_____
Malocclusion (Alignment)	[ ]	[ ]	_____
Oral Hygiene	[ ]	[ ]	_____
Other Findings	[ ]	[ ]	_____

Dentist's Recommendation:

☐ No dental treatment needed at this time

☐ Dental care needed — follow-up recommended

☐ Urgent dental issue — immediate care required

Dental Provider Information

Dentist's Name (Print): _____ Signature: _____

License Number: _____ Date of Exam: _____ / _____ / _____