

Physical Exams Are Valid For 3 Years  
From Date of Last Examination

**Please Return Completed Form to NESS**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Guardian: \_\_\_\_\_ Address: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Dates of NESS Programs: \_\_\_\_\_

**TO BE COMPLETED BY THE SPECIFIED MEDICAL PRACTITIONER:**

Date of Exam \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_ May participate in all activities  
 \_\_\_\_\_ May participate except for: \_\_\_\_\_

Medical information pertinent to routine care and emergencies:

Is this individual taking prescription or over the counter medication(s)?  YES  NO

If yes, indicate names of medication(s): \_\_\_\_\_

Does the individual have allergies?  YES  NO Explain: \_\_\_\_\_

Is the individual on a special diet?  YES  NO Explain: \_\_\_\_\_

Does the individual have special needs?  YES  NO Explain: \_\_\_\_\_

This student is up-to-date on all the following routine childhood immunizations currently recommended by the American Academy of Pediatrics and National Advisory Committee on Immunization Practices:

	Yes	No		Yes	No
Measles			Hepatitis B		
Mumps			Diphtheria		
Rubella			Pertussis		
Chickenpox			Pneumococcal conjugate		
Tetanus			Polio		

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Print name of medical care provider: \_\_\_\_\_

Medical care provider's address: \_\_\_\_\_

Medical care provider's: City/Town \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician, PA, APRN or RN

\_\_\_\_\_  
Date Form Signed

\_\_\_\_\_  
Telephone Number