North Carolina Governor's School 2023
PHYSICAL EXAMINATION FORM (2 pages)
Completed by Health Care Provider

- **A licensed physician, nurse practitioner or physician assistant must conduct a complete physical examination on this student and complete all pages of this form.**
- **An exam completed after June 1, 2022 can be referred to for completion of this form.**
- **Parent/Guardian: Once completed, upload to Registration Packet.**
- **Note: Medication Administration Plans must also be completed by the healthcare provider. These forms are turned in on Opening Day with prescription medications in-person.**

Student Legal Name _____
Last First Middle

Student Preferred Name: _____ Official Sex _____

Gender _____ Date of Birth _____

Home Address _____
Street and Number City State Zip Code

Height _____ Weight _____ Pulse _____ BP ____ / ____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

Review of Systems/Current Medical Conditions			
	NO	YES	Describe
Head, ears, nose, or throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/endocrine			
Neuropsychiatric			
Skin			
Other			

Immunization dates

Tetanus Toxoid (required within ten years) _____ Tetanus booster _____ MMR _____

D.P.T series _____ D.P.T booster _____ Polio series _____ Polio booster _____

Meningococcal vaccine _____

Other _____

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Is there loss or seriously impaired function of any paired organ? No___ Yes ___ (explain below)

_____

_____

Is the student under treatment for any medical condition? No___ Yes ___ (explain below)

_____

_____

_____

Is the student under treatment for any emotional condition? No___ Yes ___ (explain below)

_____

_____

_____

Allergies (please specify and describe treatment):

_____

_____

Chronic Conditions (please specify type and describe treatment):

_____

_____

Share any instructions or recommendations regarding restrictions, limitations, treatments or follow-ups that are deemed necessary or helpful to the student in a 4-week residential program.

_____

_____

_____

I have examined the above named student and have reviewed his/her health history. It is my opinion that this student is physically able to engage in Governor's School campus activities except as noted above.

Date of the examination _____

Name of physician, nurse practitioner or physician assistant _____

Address _____

_____ Phone _____

Signature of physician, nurse practitioner or physician assistant

_____ Date _____

NOTE: Medication Administration Plan must also be submitted and signed by the physician, nurse practitioner or physician's assistant for any currently prescribed medications to be taken at Governor's School.