North Carolina Governor’s School 2022
PHYSICAL EXAMINATION FORM (page 1 of 2)
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, 2021 can be referred to for completion of this form.
- Parent/Guardian: Once completed, upload to Registration Survey.
- 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 Name ______________________________________________________________________________
Last     First                   Middle
Sex ________      Age at time of exam ____      Date of Birth ___________________
Home Address ______________________________________________________________________________
Street and Number           City      State      Zip Code

Height _______ Weight _______   % Body Fat (optional) _____  Pulse _______  BP ____ / ____ (____/____, ____/____)

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

<table>
<thead>
<tr>
<th>Are there any abnormalities of any of the following systems?</th>
<th>NO</th>
<th>YES</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, ears, nose, or throat?</td>
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<tr>
<td>Eyes?</td>
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<tr>
<td>Respiratory?</td>
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<td>Cardiovascular?</td>
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<td>Gastrointestinal?</td>
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<td>Genitourinary?</td>
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<td>Musculoskeletal?</td>
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<td>Metabolic/endocrine?</td>
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<td>Neuropsychiatric?</td>
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<td>Skin?</td>
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<td>Menstrual history*</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
*when applicable

Immunization dates
Tetanus Toxoid (required within ten years) ________________   Tetanus booster ___________  MMR ______________
D.P.T series ___________  D.P.T booster ___________  Polio series ___________  Polio booster __________
Other ______________________________________________________________
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 prescribed medications to be taken at Governor’s School.