

PHYSICAL EXAMINATION

TO BE COMPLETED BY THE PHYSICIAN:

Child's Name: _____ Date: _____

Birthdate: _____ Age: _____ Grade: _____

HT _____ WT _____ BP _____

EYES _____ R20/ _____ L20/ _____ EARS _____ HEARING R _____ L _____

LYMPH GLANDS/THYROID _____

RESPIRATORY _____

CARDIOVASCULAR _____

ABDOMEN _____ HERNIA _____

GENITO-URINARY _____ GENITALIA _____

MUSCULOSKELETAL _____ SKIN _____

SCOLIOSIS SCREENING (if age appropriate) _____

NEUROLOGICAL _____

LABORATORY: URINALYSIS _____ HGB/HCT _____ OTHER _____

COMMENTS:

RECOMMENDATIONS:

	<u>YES</u>	<u>NO</u>
1. Any defect of vision, hearing or speech that the school could compensate for by by proper seating, etc.?	_____	_____
2. Any conditions limiting: Classroom Activity? Physical Education?	_____ _____	_____ _____
3. Any significant allergies? If yes, please specify _____	_____	_____
4. Any condition which may result in a classroom emergency? If yes, please specify _____	_____	_____
5. Any emotional, mental or physical condition requiring periodic medical observation?	_____	_____

VACCINATIONS SEE BACK OF PAGE

Comments:

Physician's Signature: _____ Date: _____

PLEASE PRINT NAME OR STAMP _____

VACCINATIONS

<u>Vaccine Type</u>	<u>1st Dose</u> <u>MO/DAY/YR</u>	<u>2nd Dose</u> <u>MO/DAY/YR</u>	<u>3rd Dose</u> <u>MO/DAY/YR</u>	<u>4th Dose</u> <u>MO/DAY/YR</u>	<u>5th Dose</u> <u>MO/DAY/YR</u>	<u>Booster</u> <u>MO/DAY/YR</u>
Diphtheria, Tetanus, Pertussis (DTP) If Td, DtaP, or DT (indicate)						
Polio Oral Polio (OPV) If Salk Vaccine, indicate IPV						
Measles, Mumps, Rubella (MMR)						
Haemophilus B (HIB)						
Hepatitis B						
Varicella						
Pneumococcal Conjugate						
Meningococcal						
Hepatitis A						
HPV (Human Papilloma Virus)						
Other- single antigen vaccine receipt, serology titers, varicella disease history, Mantoux results	<u>Date:</u> <u>Titre:</u>	<u>Date:</u> <u>Titre:</u>	<u>Date:</u> <u>Titre:</u>	<u>Date:</u> <u>Titre:</u>	<u>Date:</u> <u>Results:</u>	<u>Date:</u> <u>Results:</u>