School___________________

REPORT OF PHYSICAL EXAMINATION

Name____ Birthdate___________ Grade______ Sex_____
Last *First*

Home Address____ Home Tel#______________
 # and Street *City* *Zip*

Vaccine	Doses		*Please give exact dates*							
DtaP DPT Td	1		2		3		4		5	
	6		7							
Tdap* (Adacel)	1		2							
Polio (OPV, IPV)	1		2		3		4		5	
Hepatitis B	1		2		3					
MMR	1		2							
Varivax #1			Varivax #2				Varicella(disease)			
Meningococcal*MCV							Other			
PPD			MM results		INH Therapy		Other			

Medical History:

Allergy____ **Epi-pen** _____**Yes**_____**No**

Medical History____

____

Surgical History____

____

Examination:

Height _________**Weight** ________ **BMI for *Age Percentile*** ________ **BP**____/____ **Pulse**_____

	Normal
General Nutrition______________	☐
Skin______________	☐
Ears______________	☐
Nose & Throat______________	☐
Glands______________	☐
Heart______________	☐
Lungs______________	☐
Abdomen______________	☐

	Normal
Neuro Muscular______________	☐
Skeletal______________	☐
Emotional Status______________	☐
Hearing______________	☐
Scoliosis (Bending Pos)______________	☐
Speech______________	☐
Vision R: 20/ L: 20/	
Wears Corrective Lens Yes ☐ No ☐	

Is this student currently under treatment? No ☐ Yes ☐ ______________________________________

Please list any current or long-term medications (reason for administration): ________________

____

Should this student have any physical restrictions? ____________________________________

Signature of Examining Physician____**Phone**____________

Printed name____________________________ **Office Stamp**______________________________

Date: ___________________________

Rev 1/2010 Student Services