



PHYSICAL EXAMINATION

(To be completed by physician)

Date of Birth _____

I. **Immunizations:** Complete immunization history must be furnished. Indicate month, day, and year of vaccination.

Vaccine	Month, DAY, & Year Each Dose Was Given						Dtap Booster
DPT/Td/Tetanus							
Poliomyelitis							
Measles, Mumps, Rubella							
Hepatitis B							
Chickenpox Disease or Varicella Vaccine							
Other							

II. **Examination:** Check (X) if normal; explain if not normal.

- | | | |
|---|--|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Lungs | <input type="checkbox"/> Pulse Rate |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Menstrual | <input type="checkbox"/> Height |
| <input type="checkbox"/> Skin and scalp | <input type="checkbox"/> Genitalia | <input type="checkbox"/> Weight |
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Hernia | <input type="checkbox"/> Urinalysis |
| <input type="checkbox"/> Pharynx | <input type="checkbox"/> Extremities | |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Neurological | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Psychiatric | |
| <input type="checkbox"/> Teeth | <input type="checkbox"/> Adenopathy | |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Physical Handicap | |

III. Significant facts and physician's notes.

IV. Any prescription drugs? **WRITTEN ORDER REQUIRED.** (Please use back or attach.)

V. Can the student participate in athletics, i.e., soccer, volleyball, basketball, crosscountry, track, cheerleading, etc.?

Normal
 Moderate
 Limited
 None

VI. **Medical Certificate**

I hereby certify that _____ was examined by me on _____ Date

Signature of P.A. or R.N.P.

Signature of Physician

EXAMINATION MUST NOT BE EARLIER THAN THREE MONTHS PRIOR TO THE OPENING OF SCHOOL.