

Student Name \_\_\_\_\_

**(To be completed only by a physician)**

This form must be completed annually for students entering grades Jr. Pre-K, Kindergarten, 5, 9, and all new students.

Address \_\_\_\_\_ Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Physician's Name \_\_\_\_\_  
Sex \_\_\_\_\_ Phone Number \_\_\_\_\_

PHYSICAL EXAMINATION		RECORD OF REQUIRED IMMUNIZATIONS			
<i>(code: No Defect=0; Defect=Note)</i>		<i>Circle abbreviation of immunization administered</i>			
Height (in inches)		DPT/DTaP 1		MMR 1	
Weight		DPT/DTaP 2		MMR 2	
Eyes: required grades 1,3, & 8		DPT/DTaP 3		HPV	
Vision (Snellen) Right		DPT/DTaP 4		HPV	
Vision Left		DPT/DTaP 5		HPV	
Glasses Right					
Glasses Left				Varicella 1	
Audiometer required grades 1,4,7, & 10				Varicella 2	
Ears Right		Tdap		Hepatitis B	
Ears Left		MCV 4		Hepatitis B	
Teeth		MCV 4		Hepatitis B	
Caries				Hepatitis B	
Nose				Hepatitis A	
Throat		Polio Vaccine		Hepatitis A	
Lymph Nodes		OPV/IPV			
Thyroid		OPV/IPV		<b>TESTS</b>	
Heart		OPV/IPV		Tuberculin	
Blood Pressure		OPV/IPV		Type	Date
Lungs		MenB		Results	XRay
Abdomen		MenB		Lead Screen	
Hernia				Date	Results
Orthopedic Impairments		Other:		Sickle Cell Anemia	
Scoliosis Screening (required grades 5,7 &9)		Allergies:		(circle) Yes/No	Results
Nutrition		Ongoing Medical Concerns:		Urinalysis	
Skin			Date	Results	
Nervous System		History of severe illnesses, injuries or surgeries:			
Menstrual History		Current Medications:			
Ano-rectal					
External Genitals					
General Condition					

Physicians Recommendations:

Student physically fit to participate in physical education? Yes / No

\_\_\_\_\_  
Date Physician's Name (printed) Physician's Signature

Please complete this form and return to the front office by the first day of school, or as soon as an appointment can be scheduled.