Lower Merion School District **School _____**

PRIVATE PHYSICIANS REPORT OF PHYSICAL EXAMINATION

NAME _____BIRTH DATE _____GRADE_____SEX___
Last *First*

Home Address _____Home Tel # _____
 # and Street *City* *Zip*

IMMUNIZATION STATUS: (Please give exact dates)

Vaccine	Doses									
DTaP	1		2		3		4		5	
Polio	1		2		3		4		5	
Measles	1		2							
Mumps	1		2							
Rubella	1		2							
Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT, or TD										
Tine Date:		Results				Hib1		Hep B Vaccine		
PPD Date:		Results (MM)				2		1		
BCG Date:		INH Therapy				3		2		
Varivax:		Varicella (Disease):						3		

Medical History:

Allergy_____ **Diabetes_____**
Asthma_____ **Serious Illness_____**
Seizure Disorder_____ **Surgery_____**

Report of examination: Exam Date_____

Height_____ Weight _____ **BP____/____ Pulse_____**

	Normal		Normal
General Nutrition_____	•	Neuro Muscular _____	•
Skin _____	•	Skeleton _____	•
Ears _____	•	Emotional Status _____	•
Nose & Throat_____	•	Hearing _____	•
Glands _____	•	Scoliosis (Bending Pos) _____	•
Heart _____	•	Speech _____	•
Lungs _____	•	Vision R: 20/ L: 20/	
Abdomen _____	•	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_____

Printed name_____ Phone _____

Address _____