Lower Merion School District School PRIVATE PHYSICIANS REPORT OF PHYSICAL EXAMINATION BIRTH DATE GRADE SEX NAME _ First Last Home Address Home Tel # # and Street City Zip IMMUNIZATION STATUS: (Please give exact dates) Vaccine Doses DTaP 1 2 3 2 3 4 Polio 1 1 2 Measles 1 2 Mumps 2 Rubella 1 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) 1 2 INH Therapy **BCG Date:** 3 2 Varicella (Disease): 3 Varivax: **Medical History:** Allergy_____ **Diabetes** Serious Illness Asthma Seizure Disorder Surgery **Report of examination:** Exam Date____ Height_____ Weight _____ BP____/___Pulse_____ **Normal** Normal General Nutrition Neuro Muscular Skin Skeleton Ears Emotional Status Hearing _____ Nose & Throat 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