

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 _____
 Asthma _____
 Seizure Disorder _____

Diabetes _____
 Serious Illness _____
 Surgery _____

Report of examination:

Exam Date _____

Height _____ Weight _____

BP ____/____ Pulse _____

Normal

Normal

General Nutrition _____ •
 Skin _____ •
 Ears _____ •
 Nose & Throat _____ •
 Glands _____ •
 Heart _____ •
 Lungs _____ •
 Abdomen _____ •

Neuro Muscular _____ •
 Skeleton _____ •
 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 _____

Printed name _____ Phone _____

Address _____

