



Physical Examination Form

Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

School: _____

Grade: _____

Note any deviations from normal:

Height: _____ Weight: _____

Heart: _____

Blood Pressure: _____

Lungs: _____

General Appearance: _____

Abdomen: _____

Scalp: _____

Spine: _____

Eyes: _____

Reflexes: _____

Ears: _____

Posture: _____

Nose: _____

Feet: _____

Throat: _____

Skin: _____

Endocrine Glands: _____

Speech: _____

Nodes: _____

Allergies: _____

Social Adjustment: _____

Physical Handicap: _____

Health Habits: _____

Chronic Health Problems: _____

Has this student had any communicable diseases, serious illnesses, accidents or operations recently? _____

If yes, please note: _____

Is this student currently taking any medication? Yes _____ No _____

Comments: _____

IMMUNIZATION Date

DTP (Diphtheria, Tetanus, Pertussis)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

TD (Tetanus Diphtheria Adult Type)

- 1. _____
- 2. _____
- 3. _____

POLIO (Oral Trivalent TOPV)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

IMMUNIZATION Date

MEASLES _____

MUMPS _____

RUBELLA _____

- 1. **MMR** (combined) _____
- 2. **MMR** _____

- 1. **HEPATITIS B** _____
- 2. **HEPATITIS B** _____
- 3. **HEPATITIS B** _____

- 1. **Hib** _____
- 2. **Hib** _____
- 3. **Hib** _____
- 4. **Hib** _____

- 1. **Varicella** _____
 - 2. **Varicella** _____
- or reliable hx of chicken pox _____
 which may be:
 a. physician diagnosis
 b. physician interpretation of parent/guardian description
 c. serologic proof of immunity

SPECIAL TESTS

TUBERCULIN TEST

Results **Date**

LEAD TEST

Results **Date**

Recommendations: Abnormal Findings: _____

Please circle the following:

This student MAY MAY NOT participate in the physical education program.

This student MAY MAY NOT participate in competitive sports.

Restrictions YES NO If yes, please specify: _____

(Examiner's Name)

(Date of Exam)

(Examiner's Signature)