SCHOOL PHYSICAL

Name________________________________ Date of Birth______________

Date____________ Age______ Height______(%) Weight______(%) BP______

PHYSICAL EXAM - TO BE FILLED IN AND SIGNED BY PHYSICIAN

Posture/Gait______________________ Lungs______________________

Skin______________________ Abdomen______________________

Eyes/Vision______________________ Genitalia______________________

Ears/Hearing______________________ Neurological______________________

Throat (tonsils)______________________ Emotional______________________

Mouth (teeth)______________________ Heart______________________

Speech/Language______________________ ALLERGIES______________________

Treatment of Allergies____

Laboratory Tests *(required for preschool only) *Hgb__________ *Hct__________

(optional) Urinalysis__________ Lead__________

MAY THIS STUDENT CARRY A FULL PHYSICAL EDUCATION PROGRAM? ______________

Please explain any restrictions____

What medications, if any, is the child taking?____________________________________

PHYSICIAN'S ASSESSMENT

Problem List	Recommendations for School Management
1. ______________________	______________________
2. ______________________	______________________

IMMUNIZATION RECORD

DTaP	______	______	______	______	______
DPT	______	______	______	______	______
DT or Td	______	______	______	______	______
Polio	______	______	______	______	______
MMR	______	______	______	______	______
Hib	______	______	______	______	______
Hep B	______	______	______	______	______

Other ______________________ Date______________

TB Date______________ Test______________ Result______________

Physician's Name____

Physician's Signature______________________ Date______________