PHYSICIANS EXAMINATION FORM

Name_____DOB_____Grade_____

Illness: (Childhood Diseases, Operations, Fractures, etc.) please list: _____

Please Attach Immunization Record

Last DPT Booster_____, Polio Booster_____, MMR Booster_____
Hepatitis B Series_____, Varicella_____
Mantoux (date and result)_____ Meningococcal_____

Height_____ Weight_____ BP_____ Pulse_____
Vision_____ Glasses ___yes ___no Hearing_____
Family history of: High Blood Pressure/Heart Disease____ Diabetes ____ Seizures____

	Normal	**Abnormal/Specify**
Head/Neck		
Eyes/Sclera/Pupils		
Ears		
Nose/Mouth/Teeth/Throat		
Lymph Glands/Thyroid		
Heart/Murmur/Rhythms		
Lungs		
Chest		
Skin		
Abdomen/Liver/Spleen		
Testes/Onset of Menses		
Hernia		
Neck/Back/Spine/ROM		
Scoliosis		
Upper Extremities		
Lower Extremities		
Neurological		
Nutrition		
Orthopedic Defects		

Currently under a doctor's care for the following: _____

Currently taking the following medications: _____

Any Known Allergies: _____ Asthma: _____

Can this student fully participate in the Physical Education Program and Sports ___ yes ___ no
Restrictions: _____

Physician's Signature_____ Date of Exam_____