

SIGNATURE SCHOOL

Physical Examination Record
(To be filled out only by a physician)

Name _____ Grade _____ Date _____

Address _____ Phone # _____

Date of Birth _____ Sex _____ Family Physician _____

PHYSICAL EXAMINATION

(Code: No Defect - 0; Defect - Note)

1. Height (in inches) _____ Weight _____

2. Eyes:

Vision (Snellen) Right _____

Left _____

Glasses Right _____

Left _____

3. Ears: Right _____ Left _____

Hearing: Right _____

Left _____

4. Teeth: _____ Caries _____

5. Nose _____

6. Throat _____

7. Lymph Nodes _____

8. Thyroid _____

9. Heart _____

10. Blood Pressure _____

11. Lungs _____

12. Abdomen _____

13. Hernia _____

14. Orthopedic Impairments _____

15. Scoliosis Screening _____

16. Nutrition _____

17. Skin _____

18. Nervous Symptoms _____

19. Menstrual History _____

20. Ano-rectal _____

21. External Genitals _____

22. General Condition _____

23. History of severe illnesses, injuries or surgeries:

24. Ongoing Medical Concerns: _____

Physician's Recommendations

I recommend medical or dental attention to the following conditions:

Student physically fit to participate in physical education? Yes _____ No _____

Date

Print Physician's Name

Signature of Physician

Circle abbreviation of Immunization administered
RECORD OF REQUIRED IMMUNIZATIONS

DPT/DTaP 1. _____ MMR 1. _____

DPT/DTaP 2. _____ 2. _____

DPT/DTaP 3. _____ 3. _____

DPT/DTaP 4. _____

DPT/DTaP 5. _____ Hepatitis B

DPT/DTaP 6. _____ 1. _____

2. _____

3. _____

Td 1. _____

2. _____ HIB 1. _____

2. _____

Tdap 1. _____ 3. _____

4. _____

Polio Vaccine

OPV/ IPV 1. _____ Prevnar 1. _____

OPV/ IPV 2. _____ 2. _____

OPV/ IPV 3. _____ 3. _____

OPV/ IPV 4. _____ 4. _____

OPV/ IPV 5. _____

OPV/ IPV 6. _____ Varicella

1. _____

Meningococcal 1. _____ 2. _____

MCV4 / MPSV4 (circle) Disease Date _____

Other 1. _____ HPV 1. _____

2. _____ 2. _____

3. _____

TESTS

Tuberculin: Type _____ Date _____

Results: _____ X-Ray _____

Lead Screen: Date _____ Results _____

Sickle Cell Anemia: Yes _____ No _____ Results _____

Urinalysis: Date _____ Results _____

Allergies: _____
