

Private Physician's Report of Physical Exam

To be completed by all new students, those entering 11th grade, and all sports participants.

Name of Child _____ Birthdate _____ Grade _____ Sex _____
 Last _____ First _____ Middle _____

Immunization Status: *** Give Date of LAST BOOSTER and LAST TB TEST***

Triple Antigen (DPT) _____	Measles, Mumps, Rubella _____
Tetanus-Diphtheria (DT) _____	Measles, Mumps, Rubella Booster _____
Tetanus Toxioid _____	Measles Booster _____
TdaP _____	Mumps Booster _____
Polio Booster _____	Meningococcal _____
Varicella Vaccine _____	Varicella Booster _____
Varicella Disease Month _____ Year _____	Tuberculin Test Date _____ Result _____
Hepatitis B 1. _____ 2. _____	3. _____
Other: _____	
Hepatitis A 1. _____ 2. _____	
HPV 1. _____ 2. _____ 3. _____	

Medical History: (Give significant details, including serious illness, allergies, operations, accidents – use back if needed)

Report of Examination: (Elaborate below on abnormal findings)

B/P _____ Pulse _____ Height _____ Weight _____ Vision R 20/ _____ L 20/ _____ + Lens
 Wears Corrective Lens Yes No

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	Glands	<input type="checkbox"/>	<input type="checkbox"/>	Skeleton	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Posture	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Status	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis (bending position)	<input type="checkbox"/>	<input type="checkbox"/>
Teeth & Gingiva	<input type="checkbox"/>	<input type="checkbox"/>	Neuro Musc System	<input type="checkbox"/>	<input type="checkbox"/>			

Is the child under treatment: Yes No

Should this child have restrictions on play or physical education activities? Recommendations (use back if needed):

What other recommendations do you wish to make to the teacher or school nurse which might be of benefit to this child from the point of view of either physical or mental health (use back if needed)?

Are there any abnormal physical findings that the school needs to know about in order to let them participate in athletic programs safely (use back if needed)?

Recommendations: Full participation in sports No participation in sports Limited participation in sports

Requirements of Limited participation: _____

Signature of examining physician _____ Address _____

Physician's printed name _____ Telephone _____ Date of Examination _____