Private Physician's Report of Physical Exam

GRACE PREP HIGH SCHOOL

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) _____
Tetanus-Diphtheria (DT)_____
Tetanus Toxiod _____
TdaP _____
Polio Booster_____
Varicella Vaccine _____
Varicella Disease Month Year _____
Hepatitus B 1. _____ 2. _____ 3. _____
Other: _____
Hepatitus A 1. _____ 2. _____
HPV 1. _____ 2. _____ 3. _____

Measles, Mumps, Rubella _____
Measles, Mumps, Rubella Booster _____
Measles Booster _____
Mumps Booster _____
Meningococcal _____
Varicella Booster _____
Tuberculin Test Date _____ Result _____

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

Report of Examination: (Elaborate below on abnormal findings)

Vision R 20/ L 20/ + Lens

B/P _____ Pulse _____ Height _____ Weight _____ Wears Corrective Lens Yes ☐ No ☐

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Nutrition	☐	☐	Glands	☐	☐	Skeleton	☐	☐
Skin	☐	☐	Heart	☐	☐	Posture	☐	☐
Eyes	☐	☐	Lungs	☐	☐	Emotional Status	☐	☐
Ears	☐	☐	Abdomen	☐	☐	Hearing	☐	☐
Nose & Throat	☐	☐	Genitourinary	☐	☐	Scoliosis (bending position)	☐	☐
Teeth & Gingiva	☐	☐	Neuro Musc System	☐	☐			

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