

## Physical Examination

(To be completed by Physician)

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex : M \_\_\_ F \_\_\_

Vaccine Type	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR	MO/ DAY/ YR
Diphtheria, Tetanus, Pertussis <small>(Please Specify Type, Td, DT)</small>							
Tdap <i>**Entering grade six OR above</i>							
Polio- (Please Indicate)	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV	IPV / OPV
Measles, Mumps, Rubella (MMR)					Document single antigen, serology, varicella disease		
Haemophilus B (HIB)					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Meningococcal- (Please Indicate) <i>**Entering grade six OR above</i>	MCV4 / Non-MCV4	MCV4 / Non-MCV4	MCV4 / Non-MCV4	MCV4 / Non-MCV4	Measles	Date:	Titer:
Varicella					Mumps	Date:	Titer:
Hepatitis A					Rubella	Date:	Titer:
Pneumococcal Conjugate							
HPV (Human Papillomavirus) - <small>(Please Indicate)</small>	4 / 9	4 / 9	4 / 9				
Flu <i>**Ages 6-59 months</i>							
Other							
Mantoux TB Test <i>**See EXEMPT countries</i>	Date Given: ____ / ____ / ____		Date Read: ____ / ____ / ____		Result: ____ MM		

Date of Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ B/P: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Significant Medical / Surgical History: \_\_\_\_\_

Vision (without glasses): Rt.: 20 / \_\_\_\_ Lt.: 20 / \_\_\_\_ (with correction): Rt.: 20 / \_\_\_\_ Lt.: 20 / \_\_\_\_

Hearing: Rt.: \_\_\_\_\_ Lt.: \_\_\_\_\_ **\*\*\*Vision and Hearing MUST be completed by physician's office**

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Ears (otoscopic)				Genito-Urinary			
Eyes				Orthopedic			
Lymph Glands				Structural			
Thyroid				Posture			
Nose				Feet			
Throat				Skin			
Teeth / Mouth				Nutrition			
Heart				Nervous System			
Lungs				Speech			
Abdomen				Other			
Hernia				General Appearance			

Based on the above physical exam, this patient is capable of FULL participation in all school activities: \_\_\_\_ Yes \_\_\_\_ No

Exceptions: \_\_\_\_\_

**STAMP**

(MUST BE PRESENT FOR THIS TO BE VALID)  
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Examining Practitioner: \_\_\_\_\_