SCHOOL PHYSICAL EXAMINATION FORM

Last Name _____ First _____ Middle _____

Birth date _____ Male _____ Female _____

Parent or Guardian _____ Address _____

Physician _____ Address _____

Medicine taken regularly _____

_____

HISTORY OF ILLNESSES

Age

Allergies..... _____
Chicken Pox..... _____
Chronic Ear Infections..... _____
Epilepsy..... _____
German Measles (Rubella)..... _____
Hepatitis..... _____
Measles..... _____
Mumps..... _____
Rheumatic Fever..... _____
Scarlet fever..... _____
Other illnesses or surgery..... _____
_____
_____

IMMUNIZATIONS

Date of Immunizations

DPT					
DT					
Td					
Polio					
MMR					
HIB					
Hep B					
Varivax					

PHYSICAL EXAMINATION

General Appearance..... _____
Posture..... _____
Nutrition..... _____
Skin..... _____
Feet..... _____
Nose & Throat..... _____
Eyes & Ears..... _____
Teeth (condition)..... _____
Tonsils and Adenoids..... _____
Heart & Lungs..... _____
Abdomen..... _____
Genitals ..... _____

Height..... _____
Weight..... _____
Blood Pressure..... _____
Hgb/Hct..... _____
Urinalysis..... _____
T.B. Test..... _____
Vision: .....Right_____ Left_____
Speech..... _____
Hearing..... _____
Physician comments_____
_____
_____

Conditions that could have an effect on school performance:_____
_____
_____
_____

Examining Physician _____

Date of exam_____