SCHOOL PHYSICAL EXAMINATION FORM

Last Name_____ First_____Middle_____

Birthdate_____ 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 & Adenoids....._____
Heart & Lungs..... ..._____
Abdomen....._____
Genitals....._____

Height....._____
Weight....._____
Blood Pressure....._____
Hbg/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_____