|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Last Name | First Name | School | Grade |
|  |  |  |  |
| Birthdate | Birthplace | Sex | Phone |
|  |  |  |  |
| Parent’s Name or Guardian | Address, City, State |  | Zip |

|  |  |
| --- | --- |
| **ILLNESS / DISEASE** | **Dates of Immunization** |
| Epilepsy | Whooping Cough |
| Chickenpox | Measles (red) | Diphtheria |  |  |  |  |  |
| Diabetes | Mumps | Pertussis |  |  |  |  |  |
| TB | Rubella | Tetanus |  |  |  |  |  |
| Rheumatic Fever |  | Hib |  |  |  |  |  |
| Other Illnesses/Surgery- | Polio |  |  |  |  |  |
|  | MMR |  |  |  |  |  |
| **Allergies**- | Hep.B |  |  |  |  |  |
|  | Varicella |  |  |  |  |  |

|  |
| --- |
| ✓ = normal or negative **PHYSICAL EXAMINATION** |
| Appearance |  | Ear |  | Hernia |  |
| Posture |  | Nose |  | Back |  |
| Nutrition |  | Throat |  | Extremities |  |
| Development |  | Lymph nodes |  | Blood Pressure |  |
| Vision – R /20 L /20 | Heart |  | Hemoglobin |  |
| Neurological |  | Thyroid |  | Urine Analysis |  |
| Skin |  | Lungs |  | Height |  |
| Hair & Scalp |  | Abdomen |  | Weight |  |
| Eyes |  | Genitals |  | Other |  |
| Chronic Disease | Medications |
| Remedial Defect |
| Physical Education Program: | Full | Limited | None |  |
| Reason for Limitation |
| Physician’s Comments & Recommendations |
| Important Medical Information |
| Date of Examination |  | Physician |