|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| 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 | | | | | | |