

**PHYSICIAN'S EXAMINATION
(to be filled out by student's physician)**

Name _____ M/F _____ Birthdate _____
Grade _____ School _____

**Physical exams are recommended for students entering
Kindergarten, Grade 6 and Grade 9.**

Height _____ Weight _____ BP _____ P _____ BMI _____
Visual acuity R _____ L _____ Hearing R _____ db L _____ db

<u>yes</u>	<u>no</u>	<input type="checkbox"/>	_____ frequent headaches	<u>yes</u>	<u>no</u>	<input type="checkbox"/>	_____ toileting problem
		<input type="checkbox"/>	_____ dizziness/fainting			<input type="checkbox"/>	_____ behavior/emotional problem
		<input type="checkbox"/>	_____ seizures			<input type="checkbox"/>	_____ physical limitation
		<input type="checkbox"/>	_____ vision problem			<input type="checkbox"/>	_____ scoliosis
		<input type="checkbox"/>	_____ hearing problem			<input type="checkbox"/>	_____ heart disease
		<input type="checkbox"/>	_____ asthma/chronic cough			<input type="checkbox"/>	_____ chronic illness
		<input type="checkbox"/>	_____ allergy			<input type="checkbox"/>	_____ learning problem
		<input type="checkbox"/>	_____ frequent abdominal pain			<input type="checkbox"/>	_____ special diet needs
		<input type="checkbox"/>	_____ diabetes			<input type="checkbox"/>	_____ dental problems

Lab dates and results:

TB test _____ type _____ results _____ Rx _____
Lead screening _____ Urine _____ Hgb/Hct _____

PROBLEM LIST

1 _____
2 _____
3 _____

PLAN (meds, services, follow-ups)

**IMMUNIZATIONS: (BOLD immunizations are mandatory by state law)
(exact dates MONTH/DAY/YEAR are required for the following)**

	DPT	OPV /IPV	MMR	HIB	HBV
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____		_____	_____
	_____	_____		_____	Pneumococcal
			Other _____		_____
TD/dT	_____				

VARICELLA: vaccine date _____ or disease date _____
or titer results and date drawn _____

Student may participate in a full school program including a vigorous physical education program and interscholastic athletics. (Specify limits if needed)

Physician Name (printed)

(rev 04/03)

Physician Signature

Date of Exam