## PHYSICIAN'S EXAMINATION

Height_____ Weight_____ Blood Pressure _____ Pulse_____

Vision Without Correction: R 20/_____ L 20/_____ Both 20/_____

Vision With Correction: R 20/_____ L 20/_____ Both 20/_____

Hearing Right_____ Left _____

Nutrition (please note significant weight gain or loss in the past year) _____

Head & Neck _____ Lungs _____ Extremities _____

Nose _____ Heart _____ Neurological _____

Eyes_____ Abdomen _____ Urinalysis _____

Ears _____ Back _____ Hemoglobin\Hematocrit _____

Throat _____ Genitalia _____ Scoliosis Screening _____

Chest\Breast _____ Hernia _____ If positive, treatment? _____

Comments: _____

_____

### TO BE COMPLETED BY PHYSICIAN

A. **New Students** - Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.

**Returning Students** - Please note date of last booster and any other immunization that has been given in the last year.

| VACCINE TYPE | DISEASE DATE | 1st Dose Mo/Day/Yr | 2nd Dose Mo/Day/Yr | 3rd Dose Mo/Day/Yr | 4th Dose Mo/Day/Yr | 5th Dose Mo/Day/Yr | 6th Dose Mo/Day/Yr |
|---|---|---|---|---|---|---|---|
| Diptheria, Tetanus, Pertussis - DTP *(If DT,Td, or Tdap, write in corner box) | | | | | | | |
| Oral Polio Vaccine (OPV) If Salk Vaccine, indicate (IPV) in corner box | | | | | | | |
| MMR (Measles, Mumps & Rubella) | | | | | | | |
| Haemophilus B (HIB)** | | | | | Measles or Serology | Date | Titer |
| Hepatitis B | | | | | Rubella or Serology | Date | Titer |
| Varicella | | | | | Mumps or Serology | Date | Titer |
| Other *(Specify)* | | | | | | | |
| *DT Requires valid medical exemption ** Required for Day/Child Care (2m-5yo) | Provisional admissions attached ☐ Date Granted: | | Medical exemption attached ☐ | | Religious exemption attached ☐ | | |

B. Mantoux Tuberculin Test Date_____Result_____If positive, did student have chest X-Ray?___Result

**Based on this history/physical, this student:**

___ may participate in competitive athletics and physical education activities.

___ has health problems, which prohibit participation in the following athletic activities:

_____

_____

Physician's Name (please print) _____

Physician's Signature _____

Address _____

Telephone _____

Date of Examination: _____