

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name (PLEASE PRINT)

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck (lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: _____

IMMUNIZATION RECORD

month/day/year

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Booster	Booster
DPT/DTaP/Td/DT (diphtheria, pertussis, tetanus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis A						
Hepatitis B						
Varicella						
Pneumococcal Conjugate						
Meningococcal Vaccine						
HPV (Gardasil)						

Tuberculin Skin Test; Date: _____ Result: _____ Chest X-ray; Date: _____ Result: _____

BCG, Date: _____

Hearing Screening	1 st screening		Hearing Screening	2 nd screening		1 st Vision Screening	2 nd Vision Screening
at 25 dB	R	L	at 25 dB	R	L	Distance Acuity:	Distance Acuity:
1000 Hz			1000 Hz			R20/ ____ L-20/ ____	R-20/ ____ L-20/ ____
2000 Hz			2000 Hz			Pass ____ Refer ____	Pass ____ Refer ____
4000 Hz			4000 Hz			Fail ____	Fail ____
Date:			Date:			Signature:	Signature:

Scoliosis Screening: Pass ____ Fail ____ Refer ____ Comments: _____

Patient Health History, Findings and Recommendations:

Physical Activity: Restricted or Unrestricted (circle one) Explanation:

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school:

Date: _____ Signature: _____
(Stamped signature not accepted)

Please print physician's name and address: _____
(MD / DO or PA or RNP working under the direction of a licensed physician)