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	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	LEAD SCREENING	
Diptheria, Tetanus, Pertussis – (DTaP) *(If Td or DT, write in corner box)							
Tdap							
Polio-Inactivated Vaccine (IPV) If oral polio, write (OPV) in corner box							
MMR (Measles, Mumps & Rubella)					Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Haemophilus B (HIB)**					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Varicella					Measles	Date:	Titer:
Pneumococcal Conjugate**					Mumps	Date:	Titer:
Meningococcal					Rubella	Date:	Titer:
Hepatitis A***							
Influenza**							
HPV (Human Papillomavirus)***							
Other *(Specify)*							

*DT Requires valid medical exemption
** Required for Day/Child Care (2m-5yo)
Medical exemption attached ☐
***Not Required
Religious exemption attached ☐
Provisional admissions attached ☐
Date Granted:

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: _____