<u>THIS PHYSICAL *AND* ALL IMMUNIZATIONS *MUST BE COMPLETED BEFORE THE START OF THE SCHOOL YEAR*</u>

NEEDS:

_____ DPT _____ OPV _____ MMR _____ Hep B. ____VARIVAX

PHYSICAL EXAMINATION

Name of Child: ______________________ **Grade:** ______________________

Height: _____ **Weight:** _____ **B.P.** _____ **Rt. Or Lt. Handed** _____ **Temper Tantrums** ______

Birth Normal: ______________________ **Premature:** ______________________

Eyes: _____________ **Vision:** ___________ **Glasses Needed:** _____________

Ears: _____________ **Frequent Infections:** _____________ **Hearing:** _____________

Throat: ____________ **Nose:** ____________ **Frequent U.R.I.:** _______________

Lungs: ____________ **Heart:** _____________ **Thyroid:** _____________ **Glands:** ___________

Abdomen: _____ **Frequent c/o "stomach ache":** ______________________________________

Gen. To Urinary: __________________ **Hernia:** ______________________________________

Posture: _______ **Spine:** _______ **Speech:** _______ **Convulsions:** _______ **Fainting:** ______

Operations:

____

Injuries:

____

Allergies (Milk, Bee Stings, etc.):

____

If so, immediate steps to be taken:

____

Daily Medications:

____

Recommendations or Restrictions:

____

____

Immunizations Given :(Please document dates (mm/dd/yyyy) and type of immunization)

____

Date: ____________________ **Signature of Physician:** ________________________________