

PHYSICIAN'S REPORT OF SCHOOL HEALTH EXAMINATION

Name _____ M _____ F _____ Birth Date _____

Address _____ Name of Parent _____

HISTORY:

Allergies:

Seizures:

Serious Illness:

Hospitalizations:

Surgery:

Behavior:

Speech:

Chicken Pox (date):

Other:

IMMUNIZATIONS: Must be completed prior to school entry.

Give month, day, and year.

DPT/DT/DTaP

POLIO (Indicate IPV or OPV)

1.

1.

2.

2.

3.

3.

4.

4.

5.

5.

MMR #1 _____ HIB #1 _____ HepB #1 _____

MMR #2 _____ HIB #2 _____ HepB #2 _____

VARIVAX #1 _____ HIB #3 _____ HepB #3 _____

VARIVAX #2 _____ HIB #4 _____ TB TEST _____

PHYSICAL EXAMINATION:

HEIGHT _____ WEIGHT _____

PHARYNX _____

URINE SUGAR _____ ALBUMIN _____

LUNGS _____

GEN. BODY TYPE _____

NUTRITION _____

HEART _____ MURMURS _____

BLOOD PRESSURE _____ / _____

POSTURE _____

ABDOMEN _____ HERNIA _____

SKIN _____

GENITALIA _____

EYES _____ FUNDI _____

ORTHOPEDIC _____

VISION (R) 20/ _____ (L) 20/ _____

NEUROLOGIC _____

EARS _____

REFLEXES _____

HEARING (R) _____ (L) _____

COORDINATION _____

NOSE _____

MATURITY _____

MOUTH _____ TEETH _____

Is this child capable of carrying a full program of school work, including gymnastics and athletics:

Yes _____ No _____ Other (specify) Remarks: _____

I certify that this child has received the immunizations and tests required by State Law (RDS 200:38) for school attendance.

EXCEPTIONS: _____

Students who have not been fully immunized will not be in compliance with the law and **will not be admitted to school.**

Date: _____ Physician's Signature _____