# PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

Name of School _____ Grade _____ Teacher _____

Name of Child:

_____ _____ _____ _____ _____ _____ _____

Last First Middle Age Sex Height Weight

## RECORD OF IMMUNICATION VACCINE TYPE

| Dose Number | DT Mo/Day/Yr | Td(Adult) Mo/Day/Yr | Polio Mo/Day/Yr | Hepatitis B Mo/Day/Yr | HIB Mo/Day/Yr |
|---|---|---|---|---|---|
| 1st Dose | _____ | _____ | _____ | _____ | _____ |
| 2nd Dose | _____ | _____ | _____ | _____ | _____ |
| 3rd Dose | _____ | _____ | _____ | _____ | _____ |
| 4th Dose | _____ | _____ | _____ | _____ | _____ |
| 5th Dose | _____ | _____ | _____ | _____ | _____ |

| | Measles Mo/Day/Yr | Rubella Mo/Day/Yr | Mumps Mo/Day/Yr | Varicella | Hx Chicken Pox Mo/Day/Yr | TB Test |
|---|---|---|---|---|---|---|
| No. 1 | _____ | _____ | _____ | _____ | _____ | Date Read: _____ |
| No. 2 | _____ | _____ | _____ | _____ | _____ | Result: _____ Positive___ Negative ___ |

MEDICAL HISTORY (Give significant details, including serious illness, allergies, operations, accidents, etc.)

Report of Examination (Elaborate below on positive findings)

| | Normal | Abnormal | | Normal | Abnormal | | Normal | Abnormal |
|---|---|---|---|---|---|---|---|---|
| General Nutrition | _____ | _____ | Glands | _____ | _____ | Scoliosis | _____ | _____ |
| Skin | _____ | _____ | Heart | _____ | _____ | Posture | _____ | _____ |
| Eyes | _____ | _____ | Lungs | _____ | _____ | Emotional Status | _____ | _____ |
| Ears | _____ | _____ | Abdomen | _____ | _____ | Hearing | _____ | _____ |
| Nose & Throat | _____ | _____ | Genitalia | _____ | _____ | Vision | R20/___ | L20/ Lens |
| Teeth & Gingiva | _____ | _____ | Neuro Musc Sys | _____ | _____ | Wears Corrective Lens | Yes___ | No |

Blood Pressure _____ Urine: Sugar_____

Pulse _____ Albumen _____

Is the child under treatment? Yes _____ No _____

Should this child have restrictions on play or physical education activities? Recommendations:

What other recommendations do you wish to make to teacher or school nurse which might be of benefit to this child from the point of view of either physical or mental hygiene?

Have you seen this child previously? Yes _____ No _____

Physician's Name (Please Print)

_____ _____ _____ _____

Signature of Examining Physician Address Telephone Date