NEW YORK MILLS ELEMENTARY SCHOOL
SCHOOL YEAR _____ - _____

To the Family Physician: Date: ______________

Please complete the following form and return it to the school with your signature.

Name_________________________________ Grade______ Age_______

Height______________ Weight____________ BP______

Eyes	_________	Heart	__________
Ears (otoscopic)	_________	Lungs	__________
Lymph Nodes	_________	Hernia	__________
Thyroid	_________	Genito-Urinary	__________
Nose	_________	Orthopedic	__________
Tonsils	_________	Structure	__________
Teeth	_________	Posture	__________
Skin(non-communicable)	_________	Feet	__________
Epilepsy	_________	Scoliosis check	__________
Nervous System	_________		

Other____

____

Restrictions/Limitations____

____

History & Operations____

Allergies____

Medications____

IMMUNIZATIONS: DTP (3 or more)___________ OPV or IPV _________

MMR #1________ #2________ Varicella _________ Hepatitis B _________

Additional Comments:____

Signature of Physician:____