FRIENDS' CENTRAL SCHOOL

PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

All students must have a current report of yearly Physical Examination on file at all times.

Please note: Students without a Physician's Report on file **may not begin or attend school**. Students without a current Physician's Report on file may not participate in **athletics, off campus trips, or activities**. Forms are **valid for one year** from the date of exam, at which time a new form must be submitted.

Student's name		Grade in the fall
Street address		
City, state, and zip code		
Date of birth		Gender
Home phone	Parent's work phone	Parent's work phone

Please include area codes

IMMUNIZATIONS:

Please have your child's physician complete this immunization record, or if preferred, you may attach your physician's copy of the immunization record.

- New students: Immunization information should include all dates, including the month, day, and year of the immunization.
- Returning students: Please update only.
- ** = Vaccination required by Pennsylvania state law.

**Diphtheria, Tetanus, Acellular Pertussis (DTap, DTP, Td or DT)	1	2	3	4	5	6
**Tetanus, Diphtheria, Acellular Pertussis (Tdap)	1	2	3	4	5	6
**Polio (OPV, IPV)	1	2	3	4	5	6
**Hepatitis B	1	2	3			
**Measles, Mumps and Rubella (MMR)	1	2		Measles Serology Date:	Titer:	
**Varicella (vaccine or disease)	1	2		Rubella Serology Date:	Titer:	
**Meningococcal (MCV) Required for entry into grade 7	1	2				
Quantiferon-TB test (Required for International Students)	1	2		Mumps disease diagnosed by a physician Date:		
COVID-19 Vaccine Pfizer Moderna J&J (circle one)	1	2	3	4	5	6

Name:_____

COMMUNICABLE DISEASES	DATE
Chicken pox	
Other (specify)	

SURGERY	DATE
Ears	
Tonsils	
Hernia	
Appendix	
Other (specify)	

	NORMAL	Abnormal/Comments (use an additional sheet if needed)
Emotional status		
Ears/nose/throat		
Heart		
Hearing		
Lungs		
Abdomen		
Genitalia		
Neuro-muscular		
Skeletal-Posture (Scoliosis Bend)		

Height	Weight	Blood Pressure

VISION	right	left	both
distance	20/	20/	20/
near	20/	20/	20/
	Glasses		
	Contact Lenses		

1. Are there any recommendations you wish to make to the teacher or school nurse concerning the physical or mental health status of this student?

_____

2. Does this student have any limitations preventing full participation in the physical education or athletic programs? Please be specific.

_____

3. Is this student receiving treatment for any health conditions? (for example asthma, seizures, bleeding, diabetes, or heart problems)?

_____

4. Does this student take medication regularly? _____ If yes, please explain.

_____

5. Does this student have any food, medication, or insect sting allergies? _____ If yes, please specify.

_____

6. Does this student have an EpiPen prescribed? Yes_____ No_____

Name of physician (please print), address and telephone

X

_____

Signature of physician

_____

TODAY'S DATE **DATE OF EXAM**