

**CLINTON PUBLIC SCHOOL**

10 SCHOOL STREET  
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**STUDENT HEALTH AND PHYSICAL EXAM FORM**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex:  Male  Female

DISEASE HISTORY	TYPE/ YEAR	DISEASE HISTORY	TYPE/YEAR
Allergies		Diabetes	
Drug Sensitivities		Heart Disease	
Lyme Disease		Otitis Media	
Hepatitis		Rheumatic Fever	
Neuromuscular Disease		Strep Infections	
Asthma		Mononucleosis	
Chicken Pox		Vision Disorder	
Convulsive Disorder		Hearing Disorder	
ADHD		Congenital Defects	

**OPERATION/INJURIES (PLEASE SPECIFY):**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**ADDITIONAL COMMENTS:**


**IMMUNIZATIONS:**

VACCINE TYPE	DISEASE DATE	1 <sup>ST</sup> Dose Mo/Day/Yr	2 <sup>ND</sup> Dose Mo/Day/Yr	3 <sup>RD</sup> Dose Mo/Day/Yr	4 <sup>TH</sup> Dose Mo/Day/Yr	5 <sup>TH</sup> Dose Mo/Day/Yr
DT(a)P/DT/Td						
OPV/IPV						
MMR						
Hepatitis A						
Hepatitis B						
Varicella						
Menactra						
Prevnar						
HIB						
Rotavirus						
Gardasil						

Mantoux (PPD)	Date administered:	Date Read and Results:

**MEDICATIONS:** \_\_\_\_\_

**ALLERGIES:**

Drug: \_\_\_\_\_ Food: \_\_\_\_\_  
Environmental: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Height:	Weight:	Pulse:	B/P:
Vision:	Uncorrected	Right:	Left:
Vision:	Corrected	Right:	Left:
Hearing Screen:		Right:	Left:
	<b>Normal Exam</b>	<b>Abnormal Findings:</b>	
Head			
Eyes			
Ears			
Nose			
Throat			
Lymph Glands			
Heart			
Lungs			
Abdomen			
Hernia			
Genitalia			
Skin			
Orthopedic			
Scoliosis			
Neurological			
Speech			
Nutrition			

Any Limitation of Activity? :  No  Yes (Please define):

\_\_\_\_\_  
\_\_\_\_\_

Physician's Comments and Recommendations:

\_\_\_\_\_  
\_\_\_\_\_

Physician's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name, Address and Telephone #:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

