

**MARPLE NEWTOWN SCHOOL DISTRICT**

**A PHYSICAL EXAMINATION IS REQUIRED for original entry into school, 6<sup>th</sup> and 11<sup>th</sup> grades**

Form (Grade): \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: M \_\_\_ F \_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**IMMUNIZATION STATUS**

Vaccine (Doses)	Enter month, day & year (please give exact dates) each immunization was given				
Diphtheria-Tetanus-Pertussis (DTaP)	1	2	3	4	5
Tetanus-Diphtheria-acellular Pertussis (Tdap)	1				
Polio 4 required	1	2	3	4	
Measles-Mumps-Rubella (MMR)	1	2			
Hepatitis B	1	2	3	Hep A (1)	Hep A (2)
Meningococcal/MCV	1	2	HPV 1	HPV 2	HPV 3
Varicella (2 required or hx Dis)	1	2	Chicken Pox Disease Date:		
TB Risk Assessment ___ Negative / ___ Positive** ***If positive – Result of PPD required BCG: Date INH Therapy:					
Tuberculin Testing Type: _____ Date: _____ Result: neg.( ) pos.( )					

**HEALTH HISTORY (Give Dates, if known)**

**Allergy** \_\_\_\_\_

**Seizure Disorder** \_\_\_\_\_

**Asthma** \_\_\_\_\_

**Diabetes** \_\_\_\_\_

**Drug Allergy** \_\_\_\_\_

**Heart Disease** \_\_\_\_\_

Give significant details of child's medical history, including serious illness, operations, accidents, etc.

**Report of Examination:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ BMI %: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Emotional Status	( )	( )	Teeth	( )	( )	Skeleton	( )	( )
General Nutrition	( )	( )	Glands	( )	( )	Posture	( )	( )
Skin	( )	( )	Heart	( )	( )	Scoliosis (bending position)	( )	( )
Eyes	( )	( )	Lungs	( )	( )	Is student being observed or treated for scoliosis? Yes ___ No ___		
<b>Glasses:</b> ___ <b>Contacts:</b> ___ <b>R:</b> ___ <b>L:</b> ___			Abdomen	( )	( )			
Ears	( )	( )	Genitalia (Male)	( )	( )			
Hearing	( )	( )	Neuro-muscular	( )	( )			
Nose & Throat	( )	( )	Speech	( )	( )			

Is child under treatment? Yes \_\_\_ No \_\_\_ should this child have restrictions on play, PE or sports activities? Yes \_\_\_ No \_\_\_

Medical Diagnosis/Restrictions: \_\_\_\_\_

Medications prescribed: \_\_\_\_\_

**Life threatening health concerns will be shared with teachers unless instructed otherwise.**

*Privacy and confidentiality are maintained according to FERPA and HIPPA with consideration of the information provided above.*

Print name of Physician \_\_\_\_\_ Signature of Physician \_\_\_\_\_

Telephone: \_\_\_\_\_ Address: \_\_\_\_\_