

OFFICE OF HEALTH SERVICES & WELLNESS

Home Room Teacher \_\_\_\_\_

**Physical Examination Record**  
**(To be filled out only by a medical provider)**

Name \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Family Physician \_\_\_\_\_

**PHYSICAL EXAMINATION**

(Code: No Defect - 0; Defect - Note)

1. Height (in inches) \_\_\_\_\_ Weight \_\_\_\_\_

2. Eyes:

Vision (Snellen) Right \_\_\_\_\_

Left \_\_\_\_\_

Glasses Right \_\_\_\_\_

Left \_\_\_\_\_

3. Ears: Right \_\_\_\_\_ Left \_\_\_\_\_

Hearing: Right \_\_\_\_\_

Left \_\_\_\_\_

4. Teeth: \_\_\_\_\_ Caries \_\_\_\_\_

5. Nose \_\_\_\_\_

6. Throat \_\_\_\_\_

7. Lymph Nodes \_\_\_\_\_

8. Thyroid \_\_\_\_\_

9. Heart \_\_\_\_\_

10. Blood Pressure \_\_\_\_\_

11. Lungs \_\_\_\_\_

12. Abdomen \_\_\_\_\_

13. Hernia \_\_\_\_\_

14. Orthopedic Impairments \_\_\_\_\_

15. Scoliosis Screening \_\_\_\_\_

16. Nutrition \_\_\_\_\_

17. Skin \_\_\_\_\_

18. Nervous Symptoms \_\_\_\_\_

19. Menstrual History \_\_\_\_\_

20. Ano-rectal \_\_\_\_\_

21. External Genitals \_\_\_\_\_

22. General Condition \_\_\_\_\_

23. History of severe illnesses, injuries or surgeries: \_\_\_\_\_

24. Ongoing Medical Concerns: \_\_\_\_\_

25. Allergies \_\_\_\_\_

**Circle abbreviation of Immunization administered**  
**RECORD OF REQUIRED IMMUNIZATIONS**

DPT/DTaP 1. \_\_\_\_\_ MMR 1. \_\_\_\_\_

DPT/DTaP 2. \_\_\_\_\_ 2. \_\_\_\_\_

DPT/DTaP 3. \_\_\_\_\_ 3. \_\_\_\_\_

DPT/DTaP 4. \_\_\_\_\_

DPT/DTaP 5. \_\_\_\_\_ Hepatitis B

DPT/DTaP 6. \_\_\_\_\_ 1. \_\_\_\_\_

2. \_\_\_\_\_

Td 1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_

Tdap 1. \_\_\_\_\_ HIB 1. \_\_\_\_\_

2. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_

Polio Vaccine 4. \_\_\_\_\_

OPV/ IPV 1. \_\_\_\_\_

OPV/ IPV 2. \_\_\_\_\_ Prevnar 1. \_\_\_\_\_

OPV/ IPV 3. \_\_\_\_\_ 2. \_\_\_\_\_

OPV/ IPV 4. \_\_\_\_\_ 3. \_\_\_\_\_

OPV/ IPV 5. \_\_\_\_\_ 4. \_\_\_\_\_

OPV/ IPV 6. \_\_\_\_\_

Varicella

Meningococcal 1. \_\_\_\_\_ 1. \_\_\_\_\_

MCV4 / MPSV4 2. \_\_\_\_\_ 2. \_\_\_\_\_

Men B 1. \_\_\_\_\_ HPV 1. \_\_\_\_\_

2. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_

Hep A 1. \_\_\_\_\_

2. \_\_\_\_\_ Other 1. \_\_\_\_\_

2. \_\_\_\_\_

**TESTS (Record results if applicable):**

Tuberculin: Type \_\_\_\_\_ Date \_\_\_\_\_

Results: \_\_\_\_\_ X-Ray \_\_\_\_\_

Lead Screen : Date \_\_\_\_\_ Results \_\_\_\_\_

Sickle Cell Anemia: Yes \_\_\_\_\_ No \_\_\_\_\_ Results \_\_\_\_\_

Urinalysis: Date \_\_\_\_\_ Results \_\_\_\_\_

**Medical Provider's Recommendations**

Student physically fit to participate in physical education? Yes \_\_\_\_\_ No \_\_\_\_\_

Date \_\_\_\_\_

Print Medical Provider's Name \_\_\_\_\_

Signature of Medical Provider \_\_\_\_\_

PLEASE RETURN TO THE SCHOOL NURSE