



IT IS RECOMMENDED THAT CHILDREN HAVE A COMPLETE MEDICAL EXAMINATION BEFORE ENTERING SCHOOL. A CURRENT IMMUNIZATION RECORD IS REQUIRED AT THE TIME OF REGISTRATION. THE IMMUNIZATIONS AND TESTS BELOW ARE REQUIRED BY STATE LAW AT THE TIME OF REGISTRATION IN A SCHOOL DISTRICT.

IF PRESCHOOL ENROLLMENT, please return the School Psychologist at Rowland Elementary School.  
All other enrollments, please email the SEL District Nurse at [healthservices@selschools.org](mailto:healthservices@selschools.org)

**PLEASE FILL IN CHILD'S NAME, ADDRESS AND SCHOOL BEFORE PRESENTING TO YOUR DOCTOR**

Child's Name \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

**PHYSICAL EXAMINATION RECORDS**

**DATE OF EXAMINATION:** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_

Vision: Rt \_\_\_\_\_ Lt \_\_\_\_\_ Hearing: Rt \_\_\_\_\_ Lt \_\_\_\_\_

Referred to ear or eye specialist? \_\_\_\_\_ Yes \_\_\_\_\_ No

Nose \_\_\_\_\_ Throat \_\_\_\_\_ Mouth \_\_\_\_\_ Teeth \_\_\_\_\_

Is dental work indicated? \_\_\_\_\_ Yes \_\_\_\_\_ No

Posture \_\_\_\_\_ General Condition \_\_\_\_\_

Skin \_\_\_\_\_ Orthopedic \_\_\_\_\_

Neck \_\_\_\_\_ Nervous System \_\_\_\_\_

Heart \_\_\_\_\_ Lungs \_\_\_\_\_

Abdomen \_\_\_\_\_ Hernia \_\_\_\_\_

Genitalia \_\_\_\_\_ Urinalysis \_\_\_\_\_

**Is child in suitable condition to attend school?** \_\_\_\_\_ Yes \_\_\_\_\_ No

Remarks and Recommendations: \_\_\_\_\_

**IMMUNIZATION REQUIREMENTS (Please give month, day, year)**

DPT	#1	#2	#3	#4	#5
Polio	#1	#2	#3	#4	
MMR	#1	#2			
Hep B	#1	#2	#3		
Varicella K-11: 2 doses Gr.12: 1 dose	#1	#2			
Tdap Booster Grades 7 - 12	#1				
Meningococcal Grades 7 - 12	#1	#2			

**SIGNATURE of Healthcare Provider** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Healthcare Provider Name (PRINT / STAMP)** \_\_\_\_\_ **Phone Number** \_\_\_\_\_