# 2026-2027
# PHYSICAL EXAM AND IMMUNIZATION FORM

WILBRAHAM & MONSON ACADEMY
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***Print this form and bring it to your child's physician to complete***

Name: _____ DOB: _____ (mm/dd/yy) Date of Exam: _____ (mm/dd/yy)

**To the examining Health Care Provider:** Please correlate the student's medical history with your findings and record below. All entries must be completed.

Gender: _____ Height: _____ Weight: _____ BMI: _____

BP: _____ Pulse: _____

Vision: Right 20/_____ Left 20/_____ Vision with correction: Right 20/_____ Left 20/_____

| | Normal | Abnormal | Details |
|---|---|---|---|
| Ears/Hearing, Nose, Throat | | | |
| Mouth, Teeth, Orthodontics | | | |
| Mouth, Teeth, Orthodontics Eyes - general | | | |
| Lungs, Chest, Breasts | | | |
| Heart/Vascular | | | |
| Gastrointestinal, Nutritional | | | |
| Endocrine (Diabetes) | | | |
| Genital- Urinary (hx. UTI) | | | |
| Spine, Scoliosis, Musculoskeletal | | | |
| Skin | | | |
| Psychiatric | | | |
| Menstrual Cycle history: Specify medication or problems | | | |

**Dental or eye care needed** _____

Is this student capable of normal physical activity? _____

If not, give reasons and limitations: _____

**ALLERGIES:** _____

Is student taking any medication? _____

If so, for what purpose? _____

**Signature of Examining Health Care Provider** _____ **Date:** _____

Address: _____ Phone _____