
 Last Name First Middle

Grade _____ School _____

PHYSICIAN REPORT

Address _____

City or Town _____

Return to School Nurse

Father's Name _____

Mother's Name _____

Students are required to receive a physical examination from their health care provider upon entry into school, to obtain working papers, and to participate on an athletic squad or team.

BASIC INFORMATION

IMMUNIZATIONS

GENERAL PHYSICAL EXAMINATION

General Appearance	Give all dates including boosters	Nutritional Status
	DPT:	Nose
Height: Weight:		Ears
Vision:	Polio:	Eyes
Glasses prescribed:		Mouth
Date:		
When worn:	MMR:	Throat & Tonsils
Hearing:	Measles:	Skin
BP: Pulse:	Mumps:	Head
Prenatal experience:	Rubella:	Glands
	HIB:	Heart
Surgeries/date:	Hepatitis B:	Lungs
	Mantoux/PPD:	Genito-urinary
	Chicken Pox: (varicella)	Abdomen
<u>PHYSICAL ACTIVITY /SPORTS</u>	Meningitis:	Orthopedic – Scoliosis
Limited: Yes No If yes,	PCV: (pneumococcal)	Gastrointestinal
Describe restriction or modification:		
	Influenza:	Muscular
	Other:	Hernia
		Nervous System
		Endocrine
		Speech
		<u>MEDICATION</u>
	<u>SPECIFIC CONDITIONS</u>	Medication:
	Allergy:	Indicated for:
SIGNATURE OF PHYSICIAN/NP:	Asthma:	Dose:
	Asthma Action Plan:	Duration:
	Diabetes:	
PRINT NAME:	Seizures:	Medication:
	ADD/ADHD:	Indicated for:
DATE OF EXAMINATION:	Psychological:	Dose:
Rev. 2008	Other:	Duration: