

Student's Name: \_\_\_\_\_

**PHYSICIAN'S REPORT**

Date of Birth: \_\_\_\_\_

| IMMUNIZATIONS  |  |       |                       |   |      | NEXT IMMUNIZATION                     |                               |
|--|--|-------|-----------------------|---|------|---------------------------------------|-------------------------------|
|  | Date   | Date  | Date                  | Date  | Date | Type:                                 | Date:                         |
| chickenpox   |  |       |                       |   |      |                                       |                               |
| <b>DPT</b>   |  |       |                       |   |      |                                       |                               |
| <b>Td</b>  |  |       |                       |   |      | <b>PHYSICAL ASSESSMENT CHECK ONE:</b> |                               |
| <b>Polio Sabin (Tri)</b>                             |  |       |                       |   |      | <input type="checkbox"/>              | Entirely within normal limits |
| <b>Measles</b>                                       |  |       |                       |   |      | <input type="checkbox"/>              | Abnormalities as follows:     |
| <b>Rubella</b>                                       |  |       |                       |   |      |                                       |                               |
| <b>Mumps</b>   |  |       |                       |   |      |                                       |                               |
| <b>HIB</b> <small>All dates must be recorded</small> |  |       |                       |   |      |                                       |                               |
| Hepatitis B  |  |       |                       |   |      |                                       |                               |
| SCREENING TESTS                                      |  |       |                       |   |      | Any restricted activities:            |                               |
| VISION   | Date   | Right | Left                  |   |      |                                       |                               |
| Muscle Balance                                       |  |       |                       |   |      |                                       |                               |
| Farsightedness                                       |  |       |                       |   |      |                                       |                               |
| Color  |  |       |                       | <b>ALLERGIES</b>  |      |                                       |                               |
| Distance Acuity                                      |  |       |                       | Does the child have allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> |      |                                       |                               |
| Wears Glasses  | yes <input type="checkbox"/> no <input type="checkbox"/> |       | If so please specify: |   |      |                                       |                               |
| HEARING  |  |       |                       | <b>Signature of examining physician:</b>  |      |                                       |                               |
| TUBERCULIN   | Date   | Test  | Result                | Phone: _____  |      |                                       |                               |
|  |  |       |                       | Comments: _____   |      |                                       |                               |
| POSTURE (SCOLIOSIS)                                  | Date   | Test  | Results               | Date: _____   |      |                                       |                               |
|  |  |       |                       |   |      |                                       |                               |

