THIS SIDE TO BE COMPLETED BY PHYSICIAN **Student's Name (PLEASE PRINT)**_______________________________

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck(lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: ____

IMMUNIZATION RECORD **month/day/year**

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Booster	Booster
DPT/DTaP/Td/DT (diphtheria,pertussis,tetanus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Hepatitis A						
PCV7						
Meningococcal Vaccine						

Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result:

Hearing Screening	1st screening		Hearing Screening	2nd screening	
at 25 dB	R	L	at 25 dB	R	L
1000 Hz			1000 Hz		
2000 Hz			2000 Hz		
4000 Hz			4000 Hz		
Date:			Date:		

1st Vision Screening	2nd Vision Screening
Distance Acuity:	Distance Acuity:
R20/_____ L-20_____	R-20/_____ L-20/_____
Pass_____ Refer_____ Fail _____	Pass_____ Refer_____ Fail _____
Signature:	Signature:

Scoliosis Screening: Pass_____ Fail _____ Refer_____Comments:_______________________________

Patient Health History, Findings and Recommendations:

____

Physical Activity: Restricted or Unrestricted (circle one) Explanation:

____

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school:

Date: _________**Signature**: ____

(Stamped signature not accepted)

Please print physician's name and address: ______________________________

(MD / DO or PA or RNP working under the direction of a licensed physician) **1/09**