



2009-2010 Student Physical Form

To be completed by licensed medical physician, nurse practitioner or physician's assistant

Returning Student New Student

Name: _____ Sex: _____ DOB: _____ Grade: _____

Address: _____ Phone: _____

Date: _____ Examiner's Name: _____ Phone: _____

**PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING:
GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.**

- | | | | |
|--------------------------------------|---|-------------------------------------|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Body Piercing/Tattoo | <input type="checkbox"/> Emotional | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bone Problem | <input type="checkbox"/> Hearing | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bowel/Bladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Infections | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Vision |
| <input type="checkbox"/> OTHER _____ | | | |

Comments: _____

Height : _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Right _____ Left _____

Hearing: Right _____ Left _____

Lead Screening: (required for pre-K and Kindergarten) Date Completed _____ Results _____

Hematocrit/Hemoglobin: Date Completed _____ Results _____

TB screening within last 12 months for new students: results of risk assessment _____

OR PPD(Mantoux): Date Placed _____ Date Read _____ Results(in mm) _____

Immunizations – Shaded Vaccines Required Please complete or attach copy of record

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/Hib 4 / /	DtaP/Hib 4 / /
DTP/DTaP 1 / /	DTP/DTaP 2 / /	DTP/DTaP 3 / /	DTP/DTaP 4 / /	DTP/DTaP 5 / /
DT/Td1 / /	DT/Td 2 / /	DT/Td 3 / /	DT/Td 4 / /	DT/Td 5 / /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	OPV/IPV5 / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	
HepB 1 (2 dose) / /	HepB 2 (2 dose) / /	HepB/Hib 1 / /	HepB/Hib 2 / /	HepB/Hib 3 / /
Varicella 1 / /	Varicella 2 / /	Lyme Vax 1 / /	Lyme Vax 2 / /	Lyme Vax 3 / /
Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /	Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	
Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	HepA 1 / /	HepA 2 / /	
Influenza 1 / /	Influenza 2 / /	Tuberculosis / /	Other / /	Other / /



2009-2010 Student Physical Form, p2

Child's Name _____

Physical Exam	Normal	Abnormal	Comments
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health Problems or Special Needs Identified:

Please list any medications taken on a regular or as needed basis:

FOR CHRONIC CONDITIONS:

Please attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals:

Examiner's Signature: _____ **Date:** _____

Printed Name: _____

Address: _____ **Phone Number:** _____