STUDENT PHYSICAL EXAMINATION
(MUST BE WITHIN THE LAST YEAR)
TO BE COMPLETED BY THE PRIMARY CARE PROVIDER

Name_____ Birthdate_____ Sex M____ F____

COMPLETE IMMUNIZATION RECORD
MONTH, DAY AND YEAR OF EACH IMMUNIZATION

DPT: 4 doses one being on or after the fourth birthday or 5 doses
1_____ 2_____ 3_____ 4_____5_____

POLIO: 3 doses one being on or after the fourth birthday or 4 doses
1_____ 2_____ 3_____ 4_____

MMR/MEASLES: both after the first birthday
1_____ 2_____ 3_____

MUMPS
1_____ 2_____

RUBELLA
1_____ 2_____

HIB
1_____ 2_____ 3_____ 4_____ 5_____

HEPATITIS B
1_____2_____3_____

VARIVAX
1_____2_____

****MANTOUX**
1_____2_____
**Not mandated

MENINGOCOCCAL
1._____

PHYSICAL EXAMINATION	**PAST HISTORY AGE**
Date	Chickenpox
Height	German Measles
Weight	Measles
Ears	Mumps
Eyes	Scarlet Fever
Glands	Smallpox
Nose	Diphtheria
Throat	Pneumonia
Teeth/Mouth	Whooping Cough
Heart	Tuberculosis or Contact
Lungs	Otits Media
Abdomen	Tonsillitis
Spine	Epilepsy
Joints	Polio
Feet	Rheumatic Fever
Skin	Asthma
Nervous system	Allergies
Speech	Surgery
Blood Pressure	
Vision-OD OS	Injuries
Scoliosis	
Other	

N- within normal limits X- see comments below

Comments/Daily or PRN medication(s) child takes:_____
_____
_____
_____

Primary Care Provider's Name_____Phone number_____

Primary Care Provider's Signature/Stamp_____