CALDWELL-WEST CALDWELL PUBLIC SCHOOLS
PHYSICAL EXAMINATION AND IMMUNIZATION FORM

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN.

NAME:	☐ BOY ☐ GIRL	DATE OF BIRTH:

HEALTH HISTORY:

ALLERGIES: List all known allergies: Describe reaction and management of reaction.

Medication Allergies: Yes No ______________ ______________

Food Allergies: Yes No ______________ ______________

Insects/Animals: Yes No ______________ ______________

Environmental/ Pollens: Yes No ______________ ______________

MEDICATIONS: List all medications (prescription, over-the-counter, non-prescription) taken routinely.

Medication	Dosage/Frequency	Reason for medication

HEIGHT:	WEIGHT:	B/P:	HEART RATE:

	NORMAL	COMMENTS: (EXPLAIN ALL ABNORMAL FINDINGS)
APPEARANCE		
SKIN		
EYES/EARS/NOSE/THROAT		
LYMPH NODES		
HEART		
LUNGS		
ABDOMEN		
GENITOURINARY		
CNS		
NEUROMUSCULAR		
MUSCULO-SKELETAL		
EXTREMITIES		
SPINE		

SEIZURE DISORDER: ☐ NO ☐ YES TYPE:

SCOLIOSIS: ☐ NEGATIVE ☐ POSITIVE TREATMENT:

VISION: O.D. 20/ O.S. 20/ O.U. 20/

HEARING: RIGHT LEFT

KNOWN VISION OR HEARING PROBLEM:

DEVELOPMENT: **SPEECH:**

STUDENT MAY PARTICIPATE IN ALL PHYSICAL EDUCATION ACTIVITIES: ☐ YES ☐ NO

STUDENT MAY NOT PARTICIPATE IN THE FOLLOWING PHYSICAL ACTIVITY(IES):

PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT):	PHYSICIAN'S SIGNATURE:
TELEPHONE NUMBER:	DATE OF EXAMINATION:

Physical exam form must be <u>completed in full</u>. **05/2017**

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NAME:	☐ BOY ☐ GIRL	DATE OF BIRTH:

IMMUNIZATIONS: A COPY OF THE IMMUNIZATION RECORD IS ATTACHED: ☐ YES ☐ NO

DPT/DT/DTaP:	**OPV or IPV (circle):**	**MMR:**	**HIB:**
______ ______ ______ ______ ______ ______ **TDAP:** ______	______ ______ ______ ______ ______	______ ______	______ ______ ______ ______ ______
HEPATITIS B: ______ ______ ______	**VARIVAX:** ______ ______ **DISEASE DATE:** ______	**PNEUMOCOCCAL:** ______ ______ ______ ______ ______	**MENINGITIS VACCINE:** ______
HEPATITIS A: ______ ______	**INFLUENZA VACCINE:** ______ ______ PLEASE LIST MOST RECENT.	**OTHER:** ______ ______ ______	**OTHER:** ______ ______ ______

MANTOUX:		**LEAD LEVEL:**
DATE GIVEN: ______	RESULTS: ______	RESULTS: ______
DATE READ: ______	TREATMENT: ______	DATE TESTED: ______

PHYSICIAN'S NAME AND ADDRESS (PLEASE PRINT): TELEPHONE NUMBER:	PHYSICIAN'S SIGNATURE: