

FAMILY PHYSICIAN REPORT OF SCHOOL HEALTH EXAMINATION

NAME _____ **BIRTH DATE** _____

PARENT/GUARDIAN _____ **PHONE #** _____

ADDRESS _____

HISTORY OF PAST ILLNESSES:

Date	Date	Date
Chicken Pox _____	Rheumatic Fever _____	Contact with TB _____
Mumps _____	Scarlet Fever _____	Asthma/Allergies _____
Diabetes _____	Pneumonia _____	Ear Conditions _____
Epilepsy _____	Frequent Colds & Sore Throats _____	
Heart Disease _____	Operations _____	
Serious Injury _____		
Other _____		

IMMUNIZATION RECORD:

DPT _____	MEASLES _____	HIB _____
OPV _____	MUMPS _____	TINE _____
DT _____ Td _____	RUBELLA _____	PPD _____
MMR _____	HEP. B _____	
VARIVAX _____	OTHER _____	

PHYSICIAN' S EXAMINATION: **DATE:** _____

Height _____	Weight _____	BP _____	Genitourinary _____
Eyes/Vision _____			Orthopedic: Posture _____
Ears/Audiological _____			Structural _____
Lymph Nodes _____			Feet _____
Thyroid _____			Scoliosis Screening _____
Nose _____			Skin _____
Teeth _____			Nervous System _____
Tonsils _____			Speech _____
Heart _____			Nutrition _____
Lung _____			Hernia _____
Other _____			

OFFICE STAMP

Signature of Physician

NO MEDICATION MAY BE GIVEN IN SCHOOL WITHOUT A WRITTEN ORDER FROM A PHYSICIAN, AND ALL MEDICINES MUST BE IN THE ORIGINAL BOTTLE WITH THE PHYSICIAN' S PRESCRIPTION. FORMS ARE AVAILABLE IN EACH SCHOOL' S HEALTH OFFICE.