

MEDICAL HISTORY

DPT/TTD	11 Year	TOPV Series	Hepatitis B Vaccine
1) _____	Tdap Series	1) _____	1) _____
2) _____	2) _____	2) _____	2) _____
3) _____	3) _____	3) _____	3) _____
4) _____	4) _____	4) _____	4) _____
5) _____	5) _____	5) _____	5) _____
6) _____	6) _____	6) _____	6) _____

MMR	1) _____	2) _____	HIB Series
Or	_____	_____	1) _____
Measles	1) _____	2) _____	2) _____
Mumps	1) _____	2) _____	3) _____
Rubella	1) _____	2) _____	4) _____
Meningococcal	_____	Varivax 1) _____	Other _____
		2) _____	

MD verification of Chickenpox disease & Date _____

HCT OR Hgb _____

TUBERCULIN _____

URINALYSIS: _____

GLUCOSE _____

PROTEIN _____

VISION: R _____ L _____

HEARING: R _____ L _____

SERIOUS ILLNESSES, ALLERGIES, INJURIES, OPERATIONS OR SIGNIFICANT HISTORY _____

CHILD'S NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN: _____

GRADE: _____ TEACHER/TEAM: _____

PHYSICAL EXAMINATION- Please complete BMI appraisal on the back

1. Height _____
2. Weight _____
3. Blood Pressure _____
4. Eyes _____
5. Ears _____
6. Lymph Nodes _____
7. Thyroid _____
8. Nose _____
9. Tonsils _____
10. Heart _____
11. Lungs _____
12. Hernia _____
13. Orthopedic _____
14. Abdomen _____
15. Breast _____
16. Genitalia _____
17. Tanner Scale _____
18. Pulses _____
19. Skin _____
20. Convulsive Disorder _____
21. Nervous System _____
22. Speech _____
23. Nutrition _____
24. Asthma _____
25. Food Allergy? _____
26. Medicine Allergy? _____
27. Bee Sting Allergy? _____
28. Is child on daily medication? _____
29. Is child able to participate in Physical Education Activities? _____

Date of Examination: _____

Physician's Name (Please Print) _____

Physician's Signature _____

Phone #: _____

