MEDICAL HISTORY

DPT/Td	11 Year Tdap Series	TOPV Series	Hepatitis B Vaccine
1)________	1)________	1)________	1)________
2)________	2)________	2)________	2)________
3)________	3)________	3)________	3)________
4)________	4)________	4)________	
5)________	5)________	5)________	Hepatitis A Vaccine
6)________	6)________		1)________
			2)________

			HIB Series
MMR	1)________	2)________	1)________
Or			
Measles	1)________	2)________	2)________
Mumps	1)________	2)________	3)________
Rubella	1)________	2)________	4)________

Meningococcal ________ Varivax 1) ________ 2)________ Other ________

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__________________ GRADE: __________
ADDRESS: ____________________________________
PHONE: ______________________________________

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
    a) Structural____________
    b) Posture____________
    d) Scoliosis____________
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?
    Name of Medication: ________
    ____
29. Is child able to participate in Physical Education Activities?
    Yes_____No____

Date of Examination: ____________________

____
Physician's Name (Please Print)

____
Physician's Signature

Phone #: ____________________________