

**MEDICAL HISTORY**

DPT/Td	11 Year DTAP 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) _____

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

Meningococcal \_\_\_\_\_ Varivax \_\_\_\_\_ Other \_\_\_\_\_

MD verification of Chickenpox disease & Date \_\_\_\_\_

HCT OR Hb \_\_\_\_\_

TUBERCULIN \_\_\_\_\_

URINALYSIS:

GLUCOSE \_\_\_\_\_

PROTEIN \_\_\_\_\_

VISION: R \_\_\_\_\_ L \_\_\_\_\_

HEARING: R \_\_\_\_\_ L \_\_\_\_\_

SERIOUS ILLNESSES, ALLERGIES, INJURIES, OPERATIONS OR SIGNIFICANT HISTORY \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PARENT/L/GUARDIAN \_\_\_\_\_

GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

**PHYSICAL EXAMINATION**

- |                         |                                     |
|-------------------------|-------------------------------------|
| 1. Height _____         | 15. Breast _____                    |
| 2. Weight _____         | 16. Genitalia _____                 |
| 3. Blood Pressure _____ | 17. Pulses _____                    |
| 4. Eyes _____           | 18. Skin _____                      |
| 5. Ears _____           | 19. Convulsive Disorder _____       |
| 6. Lymph Nodes _____    | 20. Nervous System _____            |
| 7. Thyroid _____        | 21. Speech _____                    |
| 8. Nose _____           | 22. Nutrition _____                 |
| 9. Tonsils _____        | 23. Asthma _____                    |
| 10. Heart _____         | 24. Bee Sting Allergy?              |
|                         | Yes ___ No ___                      |
| 11. Lungs _____         | Name of Medication _____            |
| 12. Hernia _____        | 25. Is child on daily medication?   |
|                         | Yes ___ No ___                      |
| 13. Orthopedic          | Name of Medication _____            |
| a) Structural _____     |                                     |
| b) Posture _____        | 26. Is child able to participate in |
|                         | Physical Education Activities?      |
| d) Scoliosis _____      | Yes ___ No ___                      |
| 14. Abdomen _____       |                                     |

**Date of Examination:** \_\_\_\_\_

\_\_\_\_\_  
 Physician's Name (Please Print)

\_\_\_\_\_  
 Physician's Signature

Phone #: \_\_\_\_\_

CODE:

- N Normal or Negative
- X Observation
- XX Detect (Medical Care Needed)
- XXX Severe Defect (Immediate Care Needed)

**TO HELP US MAINTAIN OUR RECORDS CORRECTLY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:**

:

Your child's physician \_\_\_\_\_

Phone \_\_\_\_\_

Your child's dentist \_\_\_\_\_

Phone \_\_\_\_\_

Date of latest dental exam \_\_\_\_\_

Day of last eye exam \_\_\_\_\_ Examiner's Name \_\_\_\_\_

Wears glasses: Yes \_\_\_ No \_\_\_ Contact Lenses: Yes \_\_\_ No \_\_\_

ILLNESSES, INJURIES OR OPERATIONS DURING THE PAST YEAR?

\_\_\_\_\_

\_\_\_\_\_

Any other pertinent information you might wish to add?

\_\_\_\_\_

\_\_\_\_\_

It is the policy of the District to ask parents to keep children home from school for several days if they show signs of a cold or other infection.

If your child has had a fever, he/she should not return to school until his/her temperature has been normal for at **least 24 hours**.

The New York State Education Law requires an annual physical examination for pupils on entrance to the school district and routinely at grades 1, 3, 7 and 10.

If your child has a yearly examination by your family physician, please ask the physician to complete this form.

The physical examination should be completed by **October 1<sup>st</sup>**. We would appreciate having the form returned to your child's school nurse by this date. After October 1<sup>st</sup>, the school physician must examine all pupils in the grades mentioned above, and all new entrants for whom we have no record of the family physician's report.

**YORKTOWN CENTRAL SCHOOLS**

**Yorktown Heights, New York**