

REPORT ON PHYSICAL EXAMINATION

2011-2012 Academic Year

NAME OF CHILD: _____ **DATE OF BIRTH** _____
Please print

Well Child Yes No
 If no, please explain: _____

Chronic Illnesses: Asthma Yes No Other: _____
 Allergies: Yes No _____

	Normal	Abnormal		Normal	Abnormal
General	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>			
Height	_____	Weight	_____	BMI	_____
Vision	Without glasses:	R	20/_____	L	20/_____
	With glasses/lenses:	R	20/_____	L	20/_____
				Hearing L	_____
				R	_____
				Color Vision	_____

Hemoglobin Test: *(if indicated)* _____ GMS _____ BP _____
 Annual urinalysis *(required)* Sugar _____ Albumin _____ Microscopic _____
 Scoliosis screening *(requested)* _____
 Mantoux, PPD Implant _____ Date _____ Reading: _____ Date _____ Negative Positive Size _____ mm

Note: NYC DOE requires a Mantoux for all students entering any secondary school.

Does this student have a **health condition** that may require emergency action while in school or which might impact on functioning in school (e.g. seizures, bleeding problems, diabetes, heart problems, asthma)? Yes No
 If yes, please describe: _____

Does this student have any **allergies** (insect bites/stings, drugs, dust, animals, food etc.)? Yes No
 If yes, please describe: _____

Does the student have any **dietary restrictions**? Yes No
 Does the student take any **dietary supplements**? Yes No
 If there are dietary restrictions or supplements, please describe: _____

Is this student capable of unlimited participation in the athletic program? Yes No
 Is this student capable of participating in occupational therapy for this school year? Yes No
For grades K - 5 a prescription for occupational therapy must be submitted with this form

The student may be given the following medication: Benadryl Yes No
 Ibuprofen (Advil) Yes No Acetaminophen (Childrens Tylenol) Yes No None

Physician's signature: _____ Date: _____

IMMUNIZATION HISTORY

Is this child exempt from immunization?

Yes No

If yes - what is the reason?

Medical Religious

If exempted, documentation must be attached to this form

DPT/DTaP/DTTD or Tdap

Date Date Date Date Date

Polio/PV

Date Date Date Date Date

Measles

Date Date

Mumps

Date Date

Rubella

Date Date

Tetanus

Date Date Date Date Date

HB (hepatitis B)

Date Date Date Date Date

HIB

Date Date Date

Varicella

Date

Menactra

Date

Menomune

Date

Other

Type Date Type Date

** When appropriate medical documentation indicates that the student had the disease, write in M.D.DX (medically documented disease history). Documentation must be attached.*

Date of examination		
Physician Name		
Physician's Signature		
Phone number		Physicians Stamp
Address		