

**Mary McDowell Friends School**  
20 Bergen Street, Brooklyn, New York 11201 • (718) 625-3939

2010-2011 Academic Year

**REPORT ON PHYSICAL EXAMINATION**

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(please print)

**Well Child: Yes/No**  
If No, Health Problems (explain):

**Chronic Illnesses:**  
Asthma: \_\_\_\_\_ Yes \_\_\_\_\_ No Other: \_\_\_\_\_  
Allergies: \_\_\_\_\_

	<b>Normal</b>	<b>Abnormal</b>		<b>Normal</b>	<b>Abnormal</b>
<b>GENERAL</b>	_____	_____	<b>HEART</b>	_____	_____
<b>HEENT</b>	_____	_____	<b>EXTREMITIES</b>	_____	_____
<b>CHEST</b>	_____	_____			

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ **BMI** \_\_\_\_\_ Hearing: R \_\_\_\_\_ L \_\_\_\_\_

**Vision:** Without glasses R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_  
With glasses/lenses R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Color Vision \_\_\_\_\_

**Hemoglobin Test**, if indicated \_\_\_\_\_ GMS **BP** \_\_\_\_\_

**Annual urinalysis** required: Sugar \_\_\_\_\_ Albumin \_\_\_\_\_ Microscopic \_\_\_\_\_

**Scoliosis screening** requested: \_\_\_\_\_

**Mantoux, P.P.D.** \_\_\_\_\_ Implant [ ] Negative [ ] Positive \_\_\_\_\_ mm X-Ray \_\_\_\_\_  
\_\_\_\_\_ mm

**Mantoux is required for students newly entering NYC school system in Intermediate and Middle School**  
Does this student have a health condition that may require emergency action while in school or which might impact on school functioning, e.g., seizures, bleeding problems, diabetes, heart problems, asthma? Please describe:

\_\_\_\_\_

Does this student have **allergic reactions** (insect bites, stings, drugs, dust, food, etc.)? If yes, explain.

Is this student capable of **unlimited participation** in the athletic program? \_\_\_\_\_ yes \_\_\_\_\_ no

Is this student capable of **participating in OT** for this school year? \_\_\_\_\_ yes \_\_\_\_\_ no

**A script for OT must be submitted with this form for grades K-5.**

This student may be given: **Ibuprofen (Advil)** \_\_\_\_\_ **Acetaminophen** (Children's Tylenol) \_\_\_\_\_

**Benadryl** \_\_\_\_\_ **None** \_\_\_\_\_ **Other** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Dietary Restrictions:** \_\_\_\_\_

Has this student experienced any medical or surgical emergencies since the last physician's report (recent hospitalizations, fractured bones, etc.)? If so, please describe: \_\_\_\_\_

**Dietary Supplements:** \_\_\_\_\_

**IMMUNIZATION HISTORY**

EXEMPT (documentation must be attached) :      RELIGIOUS \_\_\_\_\_      MEDICAL \_\_\_\_\_

<b>DPT/ DTaP/DT TD or Tdap</b>	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)
<b>POLIO/IPV</b>	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)
<b>MEASLES*</b>	<hr/> (date)	<b>MUMPS*</b>	<hr/> (date)	<b>RUBELLA*</b>	<hr/> (date)
<b>MEASLES*</b>	<hr/> (date)	<b>MUMPS*</b>	<hr/> (date)	<b>RUBELLA*</b>	<hr/> (date)
<b>TETANUS</b>	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)
<b>HB (hepatitis B)</b>	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)	<hr/> (date)
<b>HIB</b>	<hr/> (date)	<hr/> (date)	<hr/> (date)		
<b>VARICELLA</b>	<hr/> (date)		Other	<hr/>	<hr/>
<b>MENACTRA</b>	<hr/> (date)	<b>MENOMUNE</b>	<hr/> (date)	(type & date)	(type & date)

\*When appropriate medical documentation indicates that the student had the disease, write in "M.D.DX." (medically documented disease history) and attach copy of documentation.

**Date of examination:** \_\_\_\_\_ **Physician's Signature:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Physician's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_