PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

Date of Examination__________________________

CHILD'S NAME Last / First / MI	DATE OF BIRTH	SEX ☐ ☐ M F

ADDRESS

No. and Street / City or Post Office / State / Zip Code

MEDICAL HISTORY
IMMUNIZATIONS AND TESTS

VACCINE	Enter Month, Day, And Year Each Immunization Was Given **DOSES**			**BOOSTERS & DATES**	
Diphtheria and Tetanus (Circle): DTaP, DTP, DT, Td	1	2	3	4	5
Polio (Circle): OPV, IPV	1	2	3	4	5
Measles, Mumps, Rubella	1	2			
Hepatitis B	1	2	3		
HIB	1	2	3		
Varicella	1	2	Varicella Disease or Lab Evidence Date:________________		
Other__________________					

Significant Medical Conditions (✓)

	YES	NO	If Yes, Explain
Allergies………………………	☐	☐	
Asthma…………………………	☐	☐	
Cardiac…………………………	☐	☐	
Diabetes Mellitus…………………	☐	☐	
Gastrointestinal Disorder…………	☐	☐	
Hearing Disorder…………………	☐	☐	
Hypertension……………………..	☐	☐	
Neuromuscular Disorder…………	☐	☐	
Orthopedic Condition……………	☐	☐	
Respiratory Illness………………	☐	☐	
Seizure Disorder…………………	☐	☐	
Skin Disorder……………………	☐	☐	
Vision Disorder…………………	☐	☐	
Other (Specify)…………………	☐	☐	

Are there any special medical problems or chronic diseases which require restriction of activity, medication, or which might affect his/her education? If so, specify____

Report of Physical Examination (✓)

	Normal	Abnormal	Not Examined	Comments
• Height (inches)				
• Weight (pounds) BMI				
• Pulse ( )				
• Blood Pressure /				
• Hair/Scalp				
• Skin				
• Eyes/Vision				
• Ears/Hearing				
• Nose and Throat				
• Teeth and Gingiva				
• Lymph Glands				
• Heart—Murmur, etc.				
• Lungs				
• Abdomen				
• Genitourinary				
• Neuromuscular System				
• Extremities				
• Spine (Presence of Scoliosis)				

Signature of Examiner_________________________________ Print Name of Examiner_______________________________

Address____ Telephone Number____________________________________