



**PHYSICIAN'S EXAMINATION**

\_\_\_\_\_  
Name ( Last, First )                      Grade                      Date of Birth ( M/D/Y )

\_\_\_\_\_  
Siblings (Name/grade)

**(Medical Exam must be current - within 12 months of entry date)**

(O) Normal                      (X) Abnormal    ( Comment : Specify consultation requested )

Age \_\_\_\_\_ BP \_\_\_\_\_ Hgt. \_\_\_\_\_ Wgt. \_\_\_\_\_

Nutritional Status \_\_\_\_\_ Skin \_\_\_\_\_

Eyes \_\_\_\_\_ sclera \_\_\_\_\_ pupils \_\_\_\_\_ Vision r. \_\_\_\_\_ l. \_\_\_\_\_ glasses \_\_\_\_\_

Ears \_\_\_\_\_ canals : r. \_\_\_\_\_ l. \_\_\_\_\_ drums : r. \_\_\_\_\_ l. \_\_\_\_\_

Hearing r. \_\_\_\_\_ l. \_\_\_\_\_

Mouth \_\_\_\_\_ lips \_\_\_\_\_ tongue \_\_\_\_\_ pharynx \_\_\_\_\_

Teeth \_\_\_\_\_ gingiva \_\_\_\_\_ Nose \_\_\_\_\_ septum \_\_\_\_\_ turbinates \_\_\_\_\_

Neck \_\_\_\_\_ mobility \_\_\_\_\_ lymph nodes \_\_\_\_\_ thyroid \_\_\_\_\_

Throat \_\_\_\_\_ shape \_\_\_\_\_ symmetry \_\_\_\_\_

Lungs \_\_\_\_\_ Heart \_\_\_\_\_ rate \_\_\_\_\_ rhythm \_\_\_\_\_ murmur \_\_\_\_\_

Abdomen \_\_\_\_\_ liver \_\_\_\_\_ spleen \_\_\_\_\_ hernias \_\_\_\_\_

Ano-Genital \_\_\_\_\_ anus \_\_\_\_\_ penis \_\_\_\_\_ testicles: r. \_\_\_\_\_ l. \_\_\_\_\_ labia \_\_\_\_\_

Spine \_\_\_\_\_

Lower Extremities \_\_\_\_\_ range of motion \_\_\_\_\_ development \_\_\_\_\_ strength \_\_\_\_\_

Upper Extremities \_\_\_\_\_ range of motion \_\_\_\_\_ development \_\_\_\_\_ strength \_\_\_\_\_

Cranial Nerve \_\_\_\_\_ I - XII \_\_\_\_\_ Gait \_\_\_\_\_ Coordination \_\_\_\_\_

Hyperactivity \_\_\_\_\_ Attention Deficit Disorder \_\_\_\_\_

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URINALYSIS (results) \_\_\_\_\_

HEMOGLOBIN (result) \_\_\_\_\_ gm/dl

TUBERCULIN SKIN TEST    Date \_\_\_\_\_ Result \_\_\_\_\_ Neg / Pos

A chest X - ray is required if the skin test result is positive :    Date \_\_\_\_\_ Result \_\_\_\_\_

SIS requires evidence of immunization for the following (M/D/Y) :

DTaP	#1 _____	OPV / IPV	#1 _____	MMR	#1 _____
	#2 _____		#2 _____		#2 _____
	#3 _____		#3 _____		
	#4 _____		#4 _____	Td / Tdap	_____
	#5 _____				

I have seen evidence that these have been administered.

YES \_\_\_\_\_ NO \_\_\_\_\_

Please be strict on immunization. Students who have lost records must have one OPV booster, one DTaP or Td (if between ages 11 and 18) booster, and one MMR booster along with the annual Tuberculin Skin Test. Please administer appropriate immunization for incomplete records.

Comments

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

I certify that this student has been examined by me. This examination shows that this student is physically able to participate in physical education activities, including inter-scholastic sports, unless otherwise specified above.

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

Hospital \_\_\_\_\_ Date \_\_\_\_\_

