Elementary Physical Form -

Last Name_____ First_____ Middle Initial _____ Birthdate _____ Gender_____

Address_____ City_____ Home Phone_____

Parent or Guardian_____ Family Physician_____ Address_____

Medicine Taken Regularly_____ Conditions which could affect school activities_____

PARENTS: Please complete the above area before taking to the doctor's office.

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Please check if your child has had the following illness:

1. Allergies ☐ No ☐ Yes to Medication_____ to Foods_____ Latex_____
2. Asthma ☐ No ☐ Yes Medication Name_____
3. Chicken Pox ☐ No ☐ Yes Disease Date_____
4. Diabetes ☐ No ☐ Yes _____
5. Ear Infections ☐ No ☐ Yes _____
6. Ear Tubes ☐ No ☐ Yes Date_____ Still in place?_____ R_____ L_____ Both_____
7. Pneumonia ☐ No ☐ Yes Date_____ Hospitalized? _____
8. Tonsillitis ☐ No ☐ Yes _____
9. Seizures or Epilepsy ☐ No ☐ Yes _____ If "Yes", date of last Seizure_____

PHYSICAL EXAM

Height (inches)_____ Weight (lbs) _____ Hbg _____ UA_____ Lead_____ General Appearance: ☐ Healthy

☐Other_____ Posture: ☐ Normal ☐ Other_____ Nutrition : ☐ Good ☐ Fair ☐ Poor_____

Nose & Throat ☐ Normal ☐Other _____ Eyes & Ears ☐ Normal ☐Other _____ Tonsils & Glands ☐ Normal ☐Other _____

Heart & Lungs ☐ Normal ☐Other_____ Abdomen ☐ Normal ☐Other_____

Musculoskeletal ☐ Normal ☐Other_____

Pertinent Family History _____

Operations or Injuries _____

_____

PHYSICIAN SIGNATURE_____ **DATE**_____

PHONE_____

NAME_____
Last First

IMMUNIZATIONS

(To be verified by doctor or health agency. The month, day and year are required)

Dtap Diphtheria/Tetanus/Pertussis	**1**_____	**2**_____	**3**_____	**4**_____	**5**_____
Polio	**1**_____	**2**_____	**3**_____	**4**_____	
MMR Measles/Mumps/Rubella	**1**_____	**2**_____			
Hepatitis A	**1**_____	**2**_____			
Hepatitis B	**1**_____	**2**_____	**3**_____		
Varicella	**1**_____	**2**_____			
Tdap (Grades 6-12)	**1**_____				
MCV4 (Grades 6-12)	**1**_____	**2**_____			
Prevnar (not required)	**1**_____	**2**_____	**3**_____	**4**_____	
HIB (not required)	**1**_____	**2**_____	**3**_____	**4**_____	

Physician or Health Agency Signature_____Date_____

Please turn in this completed form to the school office prior to the child's first day of school.

2/14