



**Note: A Physician must complete and sign this form.**



# Physical Exam & Immunization Form

## Landmark School

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Immunization History

Required immunization must be determined locally. This is a record of dates of basic immunization and most recent booster doses.

DTP Series _____	Booster _____	Tetanus Booster _____
Polio OPV (Sabin) _____	Booster _____	Typhoid _____
Measles Vaccine (live) _____		Tuberculin Test _____
German Measles (Rubella) _____		Mumps Vaccine (live) _____
Smallpox _____		Hep B Series 1 _____
Varicella Vaccine _____	Booster _____	2 _____
Meningococcal Vaccine _____		3 _____

### Medical Examination

This examination should be performed between May 1<sup>st</sup> and when this child enters school, to determine your patient's fitness to engage in athletic or other strenuous activities.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Hemoglobin Test: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Eyes: \_\_\_\_\_ Skin: \_\_\_\_\_

Ears: \_\_\_\_\_ Hernia: \_\_\_\_\_

Nose: \_\_\_\_\_ Extremities: \_\_\_\_\_

Throat: \_\_\_\_\_ **Allergy:**

Teeth: \_\_\_\_\_ s \_\_\_\_\_ **Please Specify** \_\_\_\_\_

Heart: \_\_\_\_\_ General Appraisal of Individual and Family: \_\_\_\_\_

Lungs: \_\_\_\_\_

Abdomen: \_\_\_\_\_

<b>Screening:</b>	(Pass) (Fail)	(Pass) (Fail)	(Pass) (Fail)
Vision: Right Eye	<input type="checkbox"/> <input type="checkbox"/>	Hearing: Right Ear	<input type="checkbox"/> <input type="checkbox"/>
Left Eye	<input type="checkbox"/> <input type="checkbox"/>	Left Ear	<input type="checkbox"/> <input type="checkbox"/>
Stereopsis	<input type="checkbox"/> <input type="checkbox"/>	Postural Screening	<input type="checkbox"/> <input type="checkbox"/>
		(Scoliosis/Kyphosis/Lordosis)	

### For Girls:

Has this person menstruated? \_\_\_\_\_ If not, has she been told about it? \_\_\_\_\_

If so, is her menstrual history normal? \_\_\_\_\_ Special Considerations: \_\_\_\_\_

**Sports: Cleared for all sports/PE** \_\_\_\_\_ **Restrictions:** \_\_\_\_\_

Special Diet: \_\_\_\_\_

Special Medicines (Please Name): \_\_\_\_\_

Dosage and Time to be Given: \_\_\_\_\_

Reason Medication is Being Given: \_\_\_\_\_

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in school activities, except as noted above.

**Examining Physician Signature:** \_\_\_\_\_ **MD Date:** \_\_\_\_\_

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