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 ___________ Gardasil ___________
Varicella Vaccine ___________ Booster ___________ Hep B Series 1 ___________
Meningococcal Vaccine ___________ 2 ___________

Medical Examination
This examination should be performed yearly. To determine your patient’s fitness to engage in athletic or other strenuous activities.

Date of Last Physical Exam. ________________

Height: _______ Weight: _______ BMI: _______ 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: _______________________________ _______________________________

Screenings: (Pass) (Fail) (Pass) (Fail) (Pass) (Fail)
*Vision: Right Eye □ □ □ *Hearing: Right Ear □ □ □ *Postural Screening □ □ □
Left Eye □ □ □ Left Ear □ □ □ (Scoliosis/Kyphosis/Lordosis □ □ □
*Annually Grades 1-5, Once 6-8, Once 9-12 *Annually K-3, Once 6-8, Once 9-12 *Annually Grades 5-9

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. Today’s Date: ________________

Examining Physician Signature: ____________________________________________________ MD: ____________________

Telephone: ___________________________ Address: ___________________________