

## Schuylerville Elementary School

NAME \_\_\_\_\_ GRADE ENTERING \_\_\_\_\_  
 DATE OF EXAM \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PHYSICAL EXAMINATION BY FAMILY DOCTOR FOR SCHOOL HEALTH RECORD

### PREVENTIVE MEASURES AND TESTS

<i>Diph-Whoop-Cgh-Tetr</i>	<i>Diph-Tetanus</i>	<i>Polio</i>	<i>MMR</i>	<i>Measles</i>	<i>Hib</i>
1. _____	1. _____	1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____			3. _____
4. _____	4. _____	4. _____	<i>Rubella</i>	<i>Mumps</i>	
Booster: _____	Booster: _____	Booster: _____	1. _____	1. _____	
				2. _____	
<i>Tdap</i> _____					

<i>Hepatitis B Vaccine</i>	<i>Varicella Vaccine</i>	<b>OR</b>	<i>Varicella Disease</i>
1. _____	1. _____		YES _____ DATE _____
2. _____			NO _____
3. _____		<b>OR</b>	
	<i>Serologic Evidence of Immunity</i>		DATE _____

If your child has had any of the above diseases, please list the name of the disease and the date the child had the disease:

Disease _____	Date _____
Disease _____	Date _____

### MEDICAL EXAMINATION

HEIGHT _____ WEIGHT _____ BMI <u>SEE ATTACHED SHEET</u> PULSE _____ B/P _____ EYES _____ LYMPH NODES _____ THYROID _____ NOSE _____ TONSILS _____ TEETH _____ HEART _____ MURMUR      YES      NO IF YES NATURE OF MURMUR _____ _____ ANY RESTRICTIONS IN ACTIVITY _____ _____ LUNGS _____ ABDOMEN _____ HERNIA _____	GENITO-URINARY _____ TANNER STAGE _____ ORTHOPEDIC _____ SCOLIOSIS _____ STRUCTURAL _____ POSTURE _____ FEET _____ SKIN _____ EPILEPSY _____ NERVOUS SYSTEM _____ SPEECH _____ NUTRITION _____ ANY OTHER _____ _____ _____ COLOR PERCEPTION _____ HEARING SCREEN      R      L VISION SCREEN      OD      OS WITH GLASSES      YES      NO
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To enable the school to better know the physical history of this child and meet his or her individual needs, we ask you to complete the following:

Does this child have any allergies which require attention at school?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please list allergies: \_\_\_\_\_

Allergy medication required? \_\_\_\_\_

Is this child on any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

Has this child ever had any significant disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what? \_\_\_\_\_

Has this child ever had surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of surgery? \_\_\_\_\_ Date \_\_\_\_\_

Has this child been hospitalized for any reason? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what reason? \_\_\_\_\_

Where? \_\_\_\_\_ Date \_\_\_\_\_

Does this child have any physical conditions or special needs that the school should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what are these needs? \_\_\_\_\_

Is this child able to participate in the regular physical education program of the school? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list any restrictions from the normal physical education program or any differences in the school program for this child:  
\_\_\_\_\_

Is this child able to participate in interscholastic sports? Yes \_\_\_\_\_ No \_\_\_\_\_

Please describe in more detail any positive findings?  
\_\_\_\_\_

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_