PRIVATE PHYSICIAN'S REPORT OF
PHYSICAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL Valley Christian School

NAME OF CHILD LAST FIRST MIDDLE	**AGE**	**GRADE**	**SEX** (CIRCLE ONE) M F	**HEIGHT** INS.	**WEIGHT** LBS.
ADDRESS NO. AND STREET CITY OR POST OFFICE BOROUGH OR TOWNSHIP COUNTY STATE ZIP					

IMMUNIZATION STATUS: (Give Date of Last Booster and Last TB Test)

	Yes	BASIC (Date)	No	BOOSTER (Date)
TRIPLE ANTIGEN (DPT)				
DTAP				
DIPHTHERIA TOXOID				
TETANUS TOXOID				

POLIO VACCINE	ORAL (Date)	SALK (Date)
TYPE I		
TYPE II		
TYPE III		
BOOSTER		

MMR #1_____, #2_____

MEASLES VACCINE Type_____ Date_____

PREVNAR _____

MENACTA _____

HEPATITIS B (DATES) #1_____, #2_____, #3 _____

VARIVAX #1 _____, #2_____

TUBERCULIN TEST – Type _____, Date _____, Result _____

OTHER (SPECIFY) _____

MEDICAL HISTORY: (Give significant details, including serious illness, allergies, operations, accidents, etc.)

REPORT OF EXAMINATION: (Elaborate below on *positive* findings)

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
GENERAL NUTRITION			GLANDS			SKELETON		
SKIN			HEART			POSTURE		
EYES			LUNGS			EMOTIONAL STATUS		
EARS			ABDOMEN			HEARING		
NOSE AND THROAT			GENITALIA (MALE)			SCOLIOSIS (Bending Position)		
TEETH AND GINGIVA			NEURO MUSCULAR SYSTEM					

BLOOD PRESSURE _____

VISION: R 20/ L 20/ + LENS
Wears corrective lens Yes _____ No _____

Is the child under treatment? Yes _____ No _____

Should this child have restrictions on play or physical education activities? Recommendations:

What other recommendations do you wish to make to teacher of school nurse which might be of benefit to this child from the point of view of either physical or mental hygiene?

SIGNATURE OF EXAMINING PHYSICIAN ADDRESS TELEPHONE

_____

DATE