Physical Exam & Immunization Form

Physician must complete and sign this form or submit a comparable form

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

Medical Examination - Required Yearly

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ HemoglobinTest: _____ Urinalysis: _____
Eyes: _____
Ears: _____
Nose: _____
Throat: _____
Teeth: _____
Heart: _____
Lungs:_____
Abdomen: _____
Skin: _____
Hernia: _____
Extremities: _____
Allergy:
Please Specify _____
General Appraisal of Individual and Family: _____
_____
_____

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 Medications (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 and athletics, except as noted above.

I examined the patient today: **Yes____ No____ If no, date of examination_____**
Examining Physician Signature_____ **Today's Date** _____
Phone_____ **Address**_____

To Parents/Guardians: Please submit completed form via mail or fax if you are unable to upload this form online to your student's Enrollment Packet:
Landmark Medical Forms, PO Box 227, Prides Crossing, MA 01965 FAX 978-921-0361