TREDYFFRIN/EASTTOWN SCHOOL DISTRICT

Physical Examination Report

Name _____ **Sex** ____ **Birthdate** _____ **Grade** ____

Immunizations	Dates Given				
Diphtheria, Pertussis, Tetanus DTap, DTP, DT, Td					
Tdap					
Polio					
Hepatitis B (indicate if 2 dose series)					
Measles - Mumps - Rubella (MMR)					
Meningococcal (MCV)					
HPV					
Other					

Chicken Pox disease _____Varicella immunization dates_____ _____

TB Test Date _____ Results _____

Allergies:

Significant Past Medical History:

Current Medications:

Current Physical Findings: **Date of Current Exam:** _____

- Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Pulse:_____

  Recommendation if abnormal _____

- Scoliosis: Normal ___ Abnormal ____Degree of Curve if abnormal _____

  Recommendation if abnormal _____

- Explain any problem of vision, hearing, or speech which requires special seating or follow-up with therapist or school nurse:

- Explain any condition which limits mobility, endurance, or physical education:

Please print or stamp

Physicians Name: Physicians Signature:_____

Address:

Phone: Date: _____