

# Our Sons and Daughters School

11 Carroll Street, Sag Harbor NY 11963  
Telephone: (631) 725 1520 Mailing: PO BOX 450 Sag Harbor NY 11963

## PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

To be completed by physician

Student's Full Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Height: Ft/In \_\_\_\_\_ Weight: \_\_\_\_\_ Posture: \_\_\_\_\_

### Condition of:

Skin \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_

Tonsils \_\_\_\_\_ Thyroid \_\_\_\_\_ Heart \_\_\_\_\_ Pulse \_\_\_\_\_

BP \_\_\_\_\_ Teeth \_\_\_\_\_ Eyes R \_\_\_\_\_ L \_\_\_\_\_ Glasses \_\_\_\_\_

Nervous System: \_\_\_\_\_

### Laboratory:

Hemoglobin: \_\_\_\_\_

### Urinalysis:

Albumin: \_\_\_\_\_ Sugar: \_\_\_\_\_

### Allergic Condition:

Hayfever: \_\_\_\_\_ Asthma: \_\_\_\_\_

### Drug

Allergies: \_\_\_\_\_

### Food

Allergies: \_\_\_\_\_

### Immunizations: Please list dates.

DPT 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

Sabin Polio 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ Varicella 1. \_\_\_\_\_ 2. \_\_\_\_\_

Measles 1. \_\_\_\_\_ 2. \_\_\_\_\_ HIB 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Mumps 1. \_\_\_\_\_ MMR 1. \_\_\_\_\_ 2. \_\_\_\_\_ Rubella 1. \_\_\_\_\_

Hep B 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Tuberculin Test (within 12 months? yes or no ) \_\_\_\_\_ results \_\_\_\_\_

Is there any physical, emotional or health problem about which the school has not been informed? If yes , please explain:

\_\_\_\_\_

Is the child currently under any medical treatment? If yes, please explain:

\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date: \_\_\_\_\_