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: _____