

PHYSICAL FORM

IMMUNIZATION	PRIMARY		BOOSTER		COMMENTS
DPT					
DT					
OPV/IPV					
MMR					
Tdap					
HIB					
TUBERCULIN	NEGATIVE <input type="checkbox"/>		POSITIVE <input type="checkbox"/>		X-RAY <input type="checkbox"/>
HEPATITUS B					
HEPATITUS A				VARIVAX	
				RUBELLA	MUMPS
					MEASLES

ALL SPACES MUST BE FILLED IN

Vision: W/O Correction R20/ _____ L/20 _____

With Correction R20/ _____ L/20 _____

Hearing : R _____ L _____

LAB: Lead Analysis _____

Drug Allergies: _____

Food Allergies: _____

Physical Problems: _____

Based on this history and physical exam, the following abnormalities were found and may need treatment:

1. _____
2. _____

Medication Currently Taken: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____

Pulse Rate: _____ BP _____

Scoliosis: Yes No

Asthma: Yes No

Inhaler: Name _____ Dose _____

Carry on person: Yes No

SPORTS PARTICIPATION RECOMMENDATIONS:

1. There is no history or physical findings on this exam which would prohibit this student from participating in competitive athletics.
2. This student should have the following health problems evaluated or treated prior to participating in competitive athletics.
3. This student has health problems which would prohibit him/her from participating in competitive athletics.

Physician's Signature _____ Date _____

Physician's Printed Name _____