

TREDYFFRIN/EASTTOWN SCHOOL DISTRICT

Physical Examination Report

Name _____ Sex _____ Birthdate _____ Grade _____

Immunizations	Dates Given				
Diphtheria, Pertussis, Tetanus,					
Tdap					
Polio					
Hepatitis B (indicate if 2 dose series)					
Measles - Mumps - Rubella (MMR)					
Meningococcal					
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: _____