HEALTH CARE PROVIDER REPORT OF PHYSICAL EXAMINATION

Student's Name _____ Birthdate _____ M F
Last First Middle Mo. Day Year Sex

Parent _____ Phone _____

Address _____
Number and Street P.O. Box City State Zip

IMMUNIZATION DATES:

	(1)	(2)	(3)	(4)	(5)
DTP/Dta/Td					
Polio					
Hepatitis					
MMR				Varicella	
Other					

TO BE COMPLETED BY MEDICAL EXAMINER

General Appearance _____

Skin _____ Eyes _____

Mouth _____ Ears _____

Teeth _____ Nose _____

Throat _____ GI _____

Cardiac _____ Respiratory _____

Neuro _____ Muscular/ Skeletal _____

Ht _____ Wt _____ BP _____

Life-threatening conditions or allergies _____

Special recommendations regarding school activities _____

SIGNATURE & TITLE OF EXAMINER _____

PRINTED NAME OF EXAMINER _____ **EXAM DATE** _____

ADDRESS OF EXAMINER _____

_____ **PHONE** _____