TABERNACLE TOWNSHIP SCHOOL DISTRICT

PHYSICAL EXAMINATION FORM ***TO BE COMPLETED BY PHYSICIAN***

Name of Student: _____ Gender: M ____ F ____

Date of Birth: _____ Name of Parent/Guardian: _____

Address: _____ Telephone #: _____

Immunization Record and Dates

	1	2	3	Booster
DPT:				
Polio:				
Measles:				
Mumps:				
Rubella:				
MMR:				

HIB: _____ HBV: _____

Varicella: _____

Disease History (Type and Year)

Allergies: _____ Insect Stings: _____

Drug Sensitivities: _____

Lyme Disease:: _____

Asthma: _____

Hepatitis: _____

Diabetes: _____

Neuromuscular Disease: _____

Congenital Defects: _____

Heart Disease: _____

Convulsive Disorder: _____

Otitis Media: _____

Pulmonary: _____

Rheumatic Fever: _____

Streptococcal Infection: _____

Other: _____

TABERNACLE TOWNSHIP SCHOOL DISTRICT

PHYSICAL EXAMINATION FORM ***TO BE COMPLETED BY PHYSICIAN***

Name of Student: _____

Operations or Injuries - Year

_____

_____

Communicable Diseases - Dates

Chicken Pox: _____ Other: _____

Health Examination

Vision: Without glasses: Rt. Eye: _____ Lt. Eye: _____

With glasses: Rt. Eye: _____ Lt. Eye: _____

Hearing: _____

Height: _____ Weight: _____

Blood Pressure: _____

Urinalysis: _____

HEENT: _____ Orthopedic-Structures: _____

Teeth-Mouth: _____ Posture: _____

Lymph Glands: _____ Feet: _____

Thyroid: _____ Extremities: _____

Heart: _____ Skin: _____

Lungs: _____ Nutrition: _____

Abdomen: _____ Nervous System: _____

Hernia: _____ Speech: _____

If applicable: G.U. _____ Other: _____

Genitalia: _____ General Appearance: _____

Recommendations: _____

Examining Physician: _____ Date: _____
(Please Print)

Physician Signature: _____