South Spencer School Corporation
Physical Exam Form

NAME_____ GRADE_____

ADDRESS_____ TELEPHONE_____

DATE OF BIRTH_____ SEX_____ FAMILY PHYSICIAN_____

ALLERGIES_____

PHYSICAL EXAM

Height_____ Weight_____
Vision: Right_____ Left_____
Glasses: Yes____ No____
Ears: Right_____ Left_____
Teeth_____ Caries_____
Nose_____
Throat_____
Lymph Nodes_____
Thyroid_____

Heart_____
Blood Pressure_____ P: _____
Lungs_____
Abdomen_____
Hernia_____
Orthopedic Impairments_____
Posture_____
Nutrition_____
Skin_____
Nervous System_____
Menstrual Cycle_____
Ano-Rectal_____
External Genitals_____
General Condition_____
History of Severe Illness, Injuries, Surgeries:
_____
_____
_____
Food Allergies/ Restrictions_____
_____

RECORD OF IMMUNIZATIONS

DTP/DTaP 1._____
DTP/DTaP 2._____
DTP/DTaP 3._____
DTP/DTaP 4._____
DTP/DTaP 5._____

Tdap 1._____

MCV4 1. _____
MCV4 2. _____

OPV/IPV 1._____
OPV/IPV 2._____
OPV/IPV 3._____
OPV/IPV 4._____
OPV/IPV 5._____

MMR 1._____
2._____

Varicella 1._____ 2._____
Date of Chickenpox Disease _____

HIB 1._____
2._____
3._____
4._____

Hep B 1._____
2._____
3._____

Prevnar 1._____
2._____
3._____
4._____

Hep A 1._____
2._____

HPV 1._____
2._____
3._____

Tests (optional)
TB test: Type_____ Date_____
Result_____X-Ray_____
Lead Screen_____ Hgb_____
Urinalysis: Date_____SG____ pH___
Other_____
Other Tests_____

Physicians Recommendations:
I recommend medical or dental attention to the following conditions_____
_____
Student is physically fit to participate in physical education: Yes_____ No_____

Date_____ Physician Signature_____