MARPLE NEWTOWN SCHOOL DISTRICT

A PHYSICAL EXAMINATION IS REQUIRED for original entry into school, 6th and 11th grades

Form (Grade): _____ Date of Exam: _____

Name of Child: _____ Date of Birth: ____/____/_____ Sex: M___ F___

Address: _____ City: _____ State: _____ Zip: _____

IMMUNIZATION STATUS

Vaccine (Doses)	Enter month, day & year (please give exact dates) each immunization was given				
Diphtheria-Tetanus-Pertussis (DTaP)	1	2	3	4	5
Tetanus-Diphtheria-acellular Pertussis (Tdap)	1				
Polio 4 required	1	2	3	4	
Measles-Mumps-Rubella (MMR)	1	2			
Hepatitis B	1	2	3	Hep A (1)	Hep A (2)
Meningococcal/MCV	1	2	HPV 1	HPV 2	HPV 3
Varicella (2 required or hx Dis)	1	2	Chicken Pox Disease Date:		
TB Risk Assessment ___Negative / ___Positive** **If positive – Result of PPD required BCG: Date INH Therapy:					
Tuberculin Testing Type: Date: Result: neg.( ) pos. ( )					

HEALTH HISTORY (Give Dates, if known)

Allergy _____ **Seizure Disorder _____**

Asthma _____ **Diabetes _____**

Drug Allergy _____ **Heart Disease _____**

Give significant details of child's medical history, including serious illness, operations, accidents, etc.

_____

Report of Examination: Height: _____ Weight: _____ BMI: _____ BMI %:_____ B/P: _____ Pulse: _____

	Normal	Abnormal
Emotional Status	( )	( )
General Nutrition	( )	( )
Skin	( )	( )
Eyes	( )	( )
Glasses:____ Contacts: ____ R: ___ L: ___		
Ears	( )	( )
Hearing	( )	( )
Nose & Throat	( )	( )

	Normal	Abnormal
Teeth	( )	( )
Glands	( )	( )
Heart	( )	( )
Lungs	( )	( )
Abdomen	( )	( )
Genitalia (Male)	( )	( )
Neuro-muscular	( )	( )
Speech	( )	( )

	Normal	Abnormal
Skeleton	( )	( )
Posture	( )	( )
Scoliosis (bending position)	( )	( )

Is student being observed or treated for scoliosis?
Yes ___ No ___

Is child under treatment? Yes ___ No ___ should this child have restrictions on play, PE or sports activities? Yes ___ No ___

Medical Diagnosis/Restrictions: _____

Medications prescribed: _____

Life threatening health concerns will be shared with teachers unless instructed otherwise.

Privacy and confidentiality are maintained according to FERPA and HIPPA with consideration of the information provided above.

Print name of Physician _____ **Signature of Physician** _____

Telephone: _____ **Address:** _____