HANCOCK PLACE SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM

This physical examination may be completed by a Medical Doctor (MD) or Doctor of Osteopathy (DO)
RETURN BY THE FIRST DAY OF SCHOOL

Student's Name_____Address_____

School_____Grade_____Date of Birth_____

Please check all items examined: Detail positive findings

Height_____Weight____Teeth/Gums_____Lymph Glands_____Urinalysis_____Nose____

Hernia_____Heart_____Throat_____Tonsils_____Ears_____Lungs_____

Skin/Hair_____ Posture_____Nutrition_____B/P_____Pulse_____Eyes_____

Vision (R)_____(L)_____Audio_____Allergies_____Orthopedic_____

Tuberculin Test_____If positive date x-ray/Treatment_____
(kind) (neg.) (positive)

Immunizaations:_____list all given with this physical.

Record of Immunizations:DPT_____ _____ _____ _____ _____

OPV_____ _____ _____ _____ _____

MMR _____ _____HiB_____

HEP B _____ _____ _____ VARIVAX_____

Positive
Finding:_____

_____

Correction or Follow Up_____

_____

Should physical activity be restricted? YES_____NO _____ If yes, specify_____

_____

SIGNED_____DATE_____