ESU #8 SCHOOL HEALTH PHYSICAL FORM

Name_____ School_____

Address_____ Date of Birth_____

Parent or Guardian_____ Phone_____

Immunizations	Month/Day/Year	Given By:
DTaP/DTP/TD (Diphtheria-Tetanus-Pertussis)	1.	
	2.	
	3.	
	4.	
	5.	
Polio	1.	
	2.	
	3.	
	4.	
	5.	
MMR (Measles-Mumps-Rubella)	1.	
	2.	
Hepatitis B	1.	
	2.	
	3.	
HIB	1.	
	2.	
	3.	
Varicella	1.	
	2.	
Other:		

Medical History	Yes	No	Comments
Allergies			
Asthma			
Diabetes			
Glasses/Vision Difficulties			
Head Injury			
Hearing Loss or Difficulties			
Heart Problems			
Orthopedic Problems			
Seizures			
Surgery			
Current Medications			

General Appearance_____ Height _____ Weight _____

Nutrition _____ Skin _____

Skeletal Development _____

Lymph Nodes _____

HEAD	Scalp _____		
	Eyes _____	Vision	1. Without Correction R _____ L _____
			2. With Correction R _____ L _____
	Ears _____	Hearing _____	
	Nose _____	Throat/Tonsils _____	
NECK	Thyroid _____		
CHEST	Heart _____ Size _____ Rate _____ Rhythm _____ BP _____		
ABDOMEN	Viscera _____	Liver _____ cm _____	
	Hernia _____	Genitals _____	
EXTREMITIES	Upper _____	Lower _____	
NEUROLOGICAL	_____		
LAB TESTS	Urinalysis _____	Hematocrit _____	
	Other _____		

RECOMMENDATIONS Physical Activity: Unrestricted _____ Moderate _____ Minimum _____

Remarks and Suggestions: _____

Date of Exam _____ Signature of Examining Physician _____