



Lower Merion School District

School _____

REPORT OF PHYSICAL EXAMINATION

Name _____ Birthdate _____ Grade _____ Sex _____

Last First

Home Address _____ Home Tel# _____

and Street City Zip

Vaccine	Doses <i>Please give exact dates</i>									
DtaP DPT Td	1		2		3		4		5	
	6		7							
Tdap* (Adacel)	1		2							
Polio (OPV, IPV)	1		2		3		4		5	
Hepatitis B	1		2		3					
MMR	1		2							
Varivax #1			Varivax #2				Varicella(disease)			
Meningococcal*MCV							Other			
PPD			MM results		INH Therapy		Other			

Medical History:

Allergy _____ Epi-pen Yes _____ No _____

Medical History _____

Surgical History _____

Examination:

Height _____ Weight _____ BMI for Age Percentile _____ BP _____ / _____ Pulse _____

Normal

General Nutrition _____

Skin _____

Ears _____

Nose & Throat _____

Glands _____

Heart _____

Lungs _____

Abdomen _____

Normal

Neuro Muscular _____

Skeletal _____

Emotional Status _____

Hearing _____

Scoliosis (Bending Pos) _____

Speech _____

Vision R: 20/ L: 20/

Wears Corrective Lens Yes No

Is this student currently under treatment? No Yes _____

Please list any current or long-term medications (reason for administration): _____

Should this student have any physical restrictions? _____

Signature of Examining Physician _____ Phone _____

Printed name _____ Office Stamp _____

Date: _____