Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name:_____ Date of Birth: ____/____/____

Allergies_____

Current Medications: (List name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

Height:_____ Weight:_____ B/P:_____

Eyes: _____

Ears: _____ **Lead Level** (if indicated):_____

Nose: _____

Throat: _____ **Sickle Cell** (If indicated):_____

Chest: _____

Heart: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given:_____

Extremities: _____ Date Read:_____

Posture/Scoliosis: _____ Results:_____

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain:_____
- Please list any condition that should be considered in planning this child's school day:_____

Immunization Record: (Month/Day/Year)

DtaP/Tdap:

1._____
2._____
3._____
4._____
5._____

IPV (please indicate if OPV)

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

Hepatitis B:

1._____
2._____
3._____

M.M.R:

1._____
2._____

Varicella:

1._____
2._____

Hepatitis A:

1._____
2._____

Pertussis:

1._____

Meningitis:

1._____
2._____

HPV:

1._____
2._____
3._____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature:_____Date_____