**PHYSICAL EXAM REPORT**

 (To be completed by your physician)

Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# IMMUNIZATIONS – Part 1

The following are the New York State minimum immunization requirements for school entrance:

* 3 DPT’s (Diptheria, Pertussis, Tetanus), 1 Tdap, 3 Polio, 2 Measles (1st Measles vaccine must be given no more that 4 days prior to the 1st birthday)
* 1 Mumps, and 1 Rubella (No more than 4 days prior to the 1st birthday)
* 3 Hepatitis B Vaccines (unless adult 2 dose series was given, which must be clearly labeled)
* 1 Varicella (No more than 4 days prior to 1st birthday or proof of disease)

Please list the dates of each vaccination.

If the child has had the disease, please list the date of the disease exposure in the last column.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Immunizations** | **1st Vaccine** | **2nd Vaccine** | **3rd Vaccine** | **4th Vaccine** | **5th Vaccine** | **6th Vaccine** | **Disease?** |
| Diphtheria-Tetanus(DT) orDiphtheria-Pertussis-Tetanus (3) |  |  |  |  |  |  |  |
| Tdap (1) |  |  |  |  |  |  |  |
| OPV/IPV |  |  |  |  |  |  |  |
| Measles–Mumps–Rubella (MMR) |  |  |  |  |  |  |  |
| Measles |  |  |  |  |  |  |  |
| Mumps |  |  |  |  |  |  |  |
| Rubella  |  |  |  |  |  |  |  |
| Hepatitis B |  |  |  |  |  |  |  |
| Varicella |  |  |  |  |  |  |  |
| Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |

**HEALTH HISTORY – Part 2**

Please check (✓) all that apply, specify and give dates.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes (✓)** | Specify | Date |
| Serious Illness |  |  |  |
| Operations |  |  |  |
| Serious Accidents |  |  |  |
| Hospitalizations |  |  |  |

|  |  |  |
| --- | --- | --- |
| \_\_\_\_ Diabetes | \_\_\_\_ Heart condition | \_\_\_\_ Stomach aches |
| \_\_\_\_ Sickle Cell Disease | \_\_\_\_ Anemia (low blood) | \_\_\_\_ Constipation |
| \_\_\_\_ Headaches | \_\_\_\_ Epilepsy | \_\_\_\_ Chicken Pox |
| \_\_\_\_ Trouble with vision/hearing | \_\_\_\_ Scoliosis | \_\_\_\_ Overweight or underweight |
| \_\_\_\_ Painful cramps w/menstruation | \_\_\_\_ Skin rashes or itching | \_\_\_\_ Other: Please list |
| \_\_\_\_ Frequent colds/sore throats | \_\_\_\_ Allergies requiring treatment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_ Sinus trouble | \_\_\_\_ Asthma  |
| \_\_\_\_ Urinary tract infections | \_\_\_\_ Painful urination  |

 **OVER**

### **HEALTH HISTORY- Part 2 (continued)**

**A Mantoux tuberculin skin test is needed only by students newly entering the school system in secondary school** (intermediate, junior high, middle school, and high school) – **and** only if they have never attended NYC Schools.

Mandatory Mantoux PPD TB Test Date \_\_\_\_\_\_\_\_\_\_\_\_\_ ⬜ positive ⬜ negative

If positive, give x-ray findings

Date of last D.T. Booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### **PHYSICAL EXAM – Part 3**

Height \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other findings:

Heart:

Lungs:

Abdomen:

Skeletal:

Vision: With Glasses R \_\_\_\_\_\_ L \_\_\_\_\_\_ Without glasses R \_\_\_\_\_\_ L \_\_\_\_\_\_

Color Vision normal \_\_\_\_\_\_ abnormal \_\_\_\_\_\_

Hearing: (Audiometric Screening):

Sweep ⬜ Pass ⬜ Fail Threshold ⬜ Pass ⬜ Fail

**Follow-up:**

Date of next appointment \_\_\_\_\_\_\_\_\_\_\_\_\_ Referred to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for consultation or workup.

**ACTIVITY LEVEL – Part 4**

⬜ Full physical activity. Student may participate in physical education classes and in all sports.

⬜ Modified Physical Activity (Please Specify)

\*Student is fit for employment if working papers are requested ⬜ Yes ⬜ No (this note is valid for one year)

**PHYSICIAN - SIGNATURE, DATE AND STAMP – Part 5**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name and address stamp Signature of Physician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of examination

## Print or type name of physician