**PHYSICAL EXAMINATION FOR COLLINGSWOOD SCHOOLS**

Name: _____ Age: _____ DOB: _____ Gender: _____

Address: _____
Street City State Zip

Home Phone: _____ School: _____ Grade: _____

Physician: _____ Phone: _____ Fax: _____

Physician's Address: _____
Street City State Zip

**PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES**

Exam Date: _____ Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ bpm.

Vision: R 20/_____ L 20/ _____ Corrected: Y / N Contacts: Y / N Glasses: Y / N Hearing: _____

| | Normal | Abnormal Findings | Comments |
|---|---|---|---|
| Head/Neck | | | |
| Eyes/Sclera/Pupils | | | |
| Ears | | | |
| Nose/Mouth/Throat | | | |
| Heart:<br>Murmurs/Rhythms | | | |
| Lungs:<br>Auscultation/Percussion | | | |
| Chest Contour | | | |
| Skin | | | |
| Abdomen:<br>Assessment (inc. liver, spleen) | | | |
| Tanner Stage:<br>Testes/Onset of Menses | | | |
| Hernia | No | Yes/Possible | |
| Neck/Back/Spine:<br>Range of Motion | | | |
| Scoliosis | | | |
| Upper Extremities | | | |
| Lower Extremities | | | |
| Neurological:<br>Balance & Coordination<br>Romberg | | | |
| Heel Walk | | | |
| Tandem Walk | | | |
| Nose Touch | | | |
| Toe Walk | | | |
| Most recent immunizations/Dates: | | | |
| Medications currently in use: | | | |
| Additional Observations/Comments: | | | |
| | | | |

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**HISTORY:** *Please check all areas where diseases or alterations have occurred and explain below:*

_____ Allergies/Anaphylaxis _____ Eczema/Skin _____Hospitalizations/Surgery
_____ Asthma/Respiratory _____ Endocrine _____ Musculoskeletal
_____ Cardiovascular/Murmur _____ Gastrointestinal _____ Neurological/Seizures
_____ Childhood diseases _____ Genitourinary _____Other

Explanation/comments: _____

_____

**CLEARANCE:**

A. Student may participate in physical education: Yes: _____ No: _____ Date: _____
B. Cleared after completing evaluation for: _____
C. **NOT CLEARED FOR:** Collision: _____ Contact: _____ Non-Contact: _____
Strenuous: _____ Moderate: _____ Non-Strenuous: _____
Diagnosis: _____
Recommendations: _____

*Only this certificate is to be used to certify that a child has met the immunization requirement for attending school. Include immunizations given on this date.* ***ALL DATES MUST INCLUDE DAY, MONTH AND YEAR.***

| VACCINE | TOTAL # DOSES | DATE | DATE | DATE | DATE | DATE |
|---|---|---|---|---|---|---|
| **DPT/DTaP** | | / / | / / | / / | / / | / / |
| **Pediatric DT*** | | / / | / / | / / | / / | / / |
| **OPV** | | / / | / / | / / | / / | / / |
| **IPV** | | / / | / / | / / | / / | / / |
| **MMR** | | / / | / / | / / | / / | / / |
| **Measles** | | / / | / / | / / | / / | / / |
| **Mumps** | | / / | / / | / / | / / | / / |
| **Rubella** | | / / | / / | / / | / / | / / |
| **Hepatitis B** | | / / | / / | / / | / / | / / |
| **HIB or Prohibit** | | / / | / / | / / | / / | / / |
| **Varicella** | | / / | / / | / / | / / | / / |
| **Pneumococcal (PCV7)** | | / / | / / | / / | / / | / / |
| **Meningococcal** | | / / | / / | / / | / / | / / |
| **RSV** | | / / | / / | / / | / / | / / |
| **Influenza** | | / / | / / | / / | / / | / / |

** Requires a physician's written medical contraindication to further pertussis vaccine when given to children under age 7.*

**TUBERCULOSIS TESTING:**

Mantoux tests: Date: _____ Result: _____Date: _____ Result: _____
Chest x-ray: Date: _____ Result: _____
INH Therapy: Date started: _____ Dosage: _____ How long: _____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider: _____ School Physician: _____

___ MD ___ DO ___ NP ___PA

_____ _____
Physician's/Provider's Signature Date

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