PHYSICAL EXAMINATION & IMMUNIZATION FORM
(to be completed, signed and dated by your Health Care Provider)

Information you provide will be used solely by Health Services as an aid to providing health care.
Students please complete demographic and health history sections before going to your health care provider

Student Name:____ D.O.B.: ________________________________

Ht: ___________ Wt.: ___________ BP: ____________ P: ____________ R: ____________

Visual Acuity: OD 20/ OS 20/ Contacts______________ Glasses_______________ Last eye exam:_____________

	Norm.	Abn.	N.E.	Comments:
Head				
Eyes				
ENT				
Teeth				
Neck (incl. thyroid)				
Chest & Lungs				
Heart				
Abdomen				
Genitalia (incl. hernia)				
(pelvic, if indicated)				
Rectal (if indicated)				
Spine				
Extremities & joints				
Neurologic				
Skin				
Emotional status				
Urinalysis				

PPD (Tuberculin skin test)	**WITHIN PAST YEAR IS REQUIRED.** Date Given _______________ Date Read________________ RESULTS ________________(mm) Chest x-ray (required if tuberculin skin test is positive) Date of chest x-ray ___________________________ Results: Normal __________ Abnormal ___________

Are you aware of any other pertinent information pertaining to this student's health that has not been addressed in the history and physical?

_____Yes ____ No If yes, what?____

____

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IMMUNIZATIONS

TO THE HEALTH CARE PROVIDER: Please review immunization records for correct dates and completeness.

(ALL CHILDHOOD IMMUNIZATION DATES MUST BE RECORDED ON THIS FORM...ATTACHMENTS WILL NOT BE ACCEPTED)

MMR	1ST DOSE AT 12-15 MONTHS, 2ND DOSE AT 4-6 YEARS OR LATER **2 INJECTIONS REQUIRED** Date 1: Date 2: Titer Date: Results:
POLIO	Primary series complete Yes Date Completed: No
DPT	Primary series complete Yes Date Completed: No
TD/Tdap Booster	Date: **(Booster must have been given within the last 10 years)**
VARICELLA (Please choose)	A history of chicken pox with proof of a positive Varicella titer OR two doses of vaccine given at least one month apart (if immunized after age 13 years) meets the requirement. 1. History of Disease Yes________ Date of positive titer _________________ 2. Immunization a. Dose #1 Date_____________ b. Dose #2 Date_____________
MENINGOCOCCAL	Quadrivalent polysaccharide vaccine Yes Date: No
HEPATITIS B [Recommended]	Dose #1: Mo._____ Yr._____ Dose #2: Mo._____ Yr._____ Dose #3: Mo._____ Yr. _____

____ _________________________________

Health Care Provider's Signature Date of Exam

____ _________________________________

Print Name Phone Number