MARPLE NEWTOWN SCHOOL DISTRICT

A PHYSICAL EXAMINATION IS REQUIRED for original entry into school, 6th and 11th grades

Form (Grade): ________ Date of Exam: ______________________

Name of Child: ______________________ Date of Birth: ____/____/____ Sex: M___ F___
Month Day Year

Address: ______________________ City: ____________ State: ________ Zip: ________

IMMUNIZATION STATUS

Vaccine (Doses)	Enter month, day & year (please give exact dates) each immunization was given				
*Diphtheria-Tetanus-Pertussis (DTP / DTaP / DT or TD)	1	2	3	4 (on or after 4thBD)	5
*Tetanus-Diphtheria (Tdap) If 5 yrs elapsed since Tetanus	1				
*Polio (3 required)	1	2	3		
*Measles (Hard, Red)	1	2			
*Rubella (German Measles)	1	2			
*Mumps	1	2			
Hepatitis B	1	2	3	Hep A (1)	Hep A (2)
Meningococcal / MCV	1		HPV 1	HPV 2	HPV 3
Varicella (2 required or hx Dis)	1	2	Chicken Pox Disease: Date:		
TB Risk Assessment ____Negative / ____Positive** **If Positive – Result of PPD required			BCG Date	INH Therapy:	
Tuberculin Testing Type:	Date:	Result:	neg. ( )	pos. ( )	

HEALTH HISTORY (Give Dates, if Known)

Allergy
Asthma
Drug Allergy
Convulsive Disorder
Diabetes
Heart Disease

Give significant details of child's medical history, including serious illness, operations, accidents, etc.

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Report of Examination

Date of Examination: ____/____/____ **Height:** ______ **Weight:** ______ **BMI** ______ **B/P:**______ **Pulse:** ______

	Normal	Abnormal
Emotional Status	( )	( )
General Nutrition	( )	( )
Skin	( )	( )
Eyes	( )	( )
Glasses: Contact Lens: R: L:		
Ears	( )	( )
Hearing	( )	( )
Nose & Throat	( )	( )

	Normal	Abnormal
Teeth	( )	( )
Glands	( )	( )
Heart	( )	( )
Lungs	( )	( )
Abdomen	( )	( )
Genitalia (Male)	( )	( )
Neuro-muscular	( )	( )
Speech	( )	( )

	Normal	Abnormal
Skeleton	( )	( )
Posture	( )	( )
Scoliosis: (bending position)	( )	( )
Is student under observation for or treatment of scoliosis?		

Is Child under treatment? Yes ( ) No ( ) should this child have restrictions on play, physical education or sports activities? Yes ( ) No ( )

Medical Diagnosis/Restrictions: ______________________________

Medications prescribed: ______________________________

Life threatening health concerns will be shared with teachers unless instructed otherwise.

Privacy and confidentiality is maintained according to the Family Education Rights and Privacy Act as well as the Health Insurance Portability and Accountability Act with consideration of the information provided above.

______________________ ______________________
Print name of Physician **Signature of Physician**

Telephone: ______________ Address: ______________________