

**TREDYFFRIN/EASTTOWN SCHOOL DISTRICT**  
**Physical Examination Report**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthday \_\_\_\_\_ Grade \_\_\_\_\_

**Immunization**

**Dates Given**

Diphtheria, Pertussis, Tetanus					
Polio					
Hepatitis B (indicate if 2 dose series)					
Measles – Mumps – Rubella (MMR)					
Other					

Chicken Pox Disease \_\_\_\_\_ Varicella Immunization Dates \_\_\_\_\_

TB Test Dates \_\_\_\_\_ Results \_\_\_\_\_

**Allergies:**

**Significant Past Medical History:**

**Current Medications:**

**Current Physical Findings:**

**Date of Current Exam:** \_\_\_\_\_

- Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Recommendation if abnormal \_\_\_\_\_

- Scoliosis: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Degree of Curve if abnormal \_\_\_\_\_

Recommendation if abnormal \_\_\_\_\_

- Explain any problems of vision, hearing or speech which requires special seating or follow-up with therapist or school nurse:

- Explain any condition which limits mobility, endurance or physical education:

**Please print or stamp**

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_