

Physician Certificate of Examination Form**(To be completed by a physician)****Please Print!**

Name: _____ Date of Birth: ____/____/____

Allergies _____

Current Medications: (List name, dosage, and time)

1. _____ Dosage _____ Time _____

2. _____ Dosage _____ Time _____

Height: _____ Weight: _____ B/P: _____

Eyes: _____

Ears: _____

Lead Level (if indicated): _____

Nose: _____

Throat: _____

Sickle Cell (If indicated): _____

Chest: _____

Heart: _____

P.P.D.: (Recommended)

Hernia: _____

Date Given: _____

Extremities: _____

Date Read: _____

Posture/Scoliosis: _____

Results: _____

- Physically fit to participate in all physical education programs? Yes No
If "No" please explain: _____
- Please list any condition that should be considered in planning this child's school day: _____

Immunization Record: (Month/Day/Year)

DtaP/Tdap:

1. _____

2. _____

3. _____

4. _____

5. _____

Hepatitis B:

1. _____

2. _____

3. _____

Hepatitis A:

1. _____

2. _____

Pertussis:

1. _____

Meningitis:

1. _____

2. _____

IPV (please indicate if OPV)

1. _____

2. _____

3. _____

4. _____

1. _____

2. _____

Varicella:

1. _____

2. _____

HPV:

1. _____

2. _____

3. _____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature: _____ Date _____