PHYSICIAN PHYSICAL EXAMINATION (TO BE COMPLETED BY PHYSICIAN) *Page 1 of 2*

Complete form and forward to: District Registrar
Central Valley School District
111 Frederick Street
Ilion, NY 13357

Phone: 315-894-3210
Fax: 315-894-3274

New York State Regulations require that before entering school, a child must have a physical examination and be on a regular schedule for completing required immunizations. The physician is requested to complete pertinent information on this form and check vaccinations schedule to make recommendations for completing the required immunizations.

(Legal name only) Last name:	First:	Middle:	Suffix (Jr., II, III):	Gender: ☐ Male ☐ Female
Date of Birth:	School:	Grade Level:	Date of physical:	

Height (inches)		Structural: 1. Scoliosis Check	
Weight		2. Posture	
BMI		3. Feet	
BMI %		Teeth	
Blood Pressure		Nose	
Urinalysis: Albumen/Sugar		Heart	
Blood Count/HCT		Abdomen	
Nervous System (Neurological)		Lungs	
Ears (Otoscopic) or Auditory		Skin	
Hernia		Eyes	
Speech/Language		Nutrition	
Lymph Nodes (Lymphatic)		Genito-Urinary	
Psycho-Motor Development		Tanner Stage	
Lead Screening/Results		Tine Test – Tuberculin	
		Tonsils	

Specific recommendations or remarks:

Is there a condition that may require a classroom emergency? ☐ No ☐ Yes If yes, explain:

Is there a condition that may require a limitation or compensation in the school environment, program, or physical education?
☐ No ☐ Yes If yes, explain:

Is this child on regular medication or under regular medical observation? ☐ No ☐ Yes If yes, explain:

(If child needs medication administered in school, a medication request form must be completed and signed by a physician before medication will be given at school.)

Should this child be seen by you again? ☐ No ☐ Yes If yes, when?

Physician's name (printed): Physician's signature:

Address: Phone:

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IIMMUNIZATIONS/HEALTH HISTORY

☐ Immunization record attached ☐ No immunizations given today

Immunizations given since last health appraisal: _____

Sickle Cell Screen:	☐ Positive	☐ Negative	☐ Not Done	Date: _____
PPD:	☐ Positive	☐ Negative	☐ Not Done	Date: _____
Elevated Lead:	☐ Positive	☐ Negative	☐ Not Done	Date: _____
Dental Referral:	☐ Positive	☐ Negative	☐ Not Done	Date: _____

Significant Medical/Surgical History: ☐ See attached

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension

☐ Other: _____

Allergies: ☐ Life Threatening ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____

☐ Seasonal ☐ Medication: _____

Vision: Without glasses/contact lenses R: _____ L: _____ Referral: _____

With glasses/contact lenses: R: _____ L: _____ Referral: _____

Near point: R: _____ L: _____ Referral: _____

Hearing: ☐ Pass 20 dB sc both ears or: R: _____ L: _____ Referral: _____

Immunizations	Give dates by month/day/year				
Oral Polio vaccine	#1	#2	#3	#4	#5
D.P.T. (Diphtheria/Pertussis/Tetaus) D.T. or DPAT/DT	#1	#2	#3	#4	#5
Hep. B	#1	#2	#3		
Measles	#1	#2			
Mumps	#1	#2			
Rubella (three-day measles)	#1	#2			
Tuberculin Test					
Chicken Pox vaccine					
Menactra					
Hib/B-Capsa	#1	#2	#3	#4	
Prevnar/Pneumonia	#1	#2	#3	#4	
Influenza	#1	#2	#3	#4	#5

If child is exempt from any vaccination, please specify vaccine and reason:

Additional comments:

Physician's name (printed): Physician's signature:

Address:

Phone: Fax: Date completed: