Oceanside Union Free School District
Oceanside, NY 11572

Physical Examination

School #_____ Grade_____

The law requires that all pupils in public schools be examined by a physician upon entrance to each school, and upon entering kindergarten, second, fourth, seventh, and tenth grades. Examination by the family physician is recommended annually.

Please return the completed form to the pupil's classroom teacher when the pupil is examined by the family physician, physician assistant, or nurse practitioner.

Child's Name_____
Date of Birth_____
Height_____ Weight_____
BMI_____ Percentile_____
Eyes- vision with glasses R_____ L_____
vision w/o glasses R_____ L_____
Hearing _____
Ears- Otoscopic _____
Genito-Urinary _____
Urinalysis _____
Heart_____ Blood Pressure_____
Lungs_____
Lymph Nodes_____
Nervous System- Specify
if epileptic_____
Nose_____
Nutrition_____
Orthopedic_____
Including Scoliosis_____

Skin_____
Speech_____
Thyroid_____
Tonsils_____
Allergies_____
Other _____
_____
CURRENT MEDICATIONS AND TREATMENTS____
_____
_____
_____
MEDICAL/SURGICAL HISTORY _____
_____
Explanation _____

Date of Examination_____

INITIAL IMMUNIZATIONS AND BOOSTERS

DPT (1)_____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

DT _____
DTap_____
Tdap_____
Polio (TOPV) Oral/IVP
(1)_____ (4) _____
(2)_____ (5)_____
(3)_____ (6)_____
Varicella Disease _____
Varivax (1) _____ (2) _____
MMR (1) _____ (2) _____
or
Measles _____
Mumps _____
Rubella _____
HIB (1) _____ (2) _____ (3) _____
Hep A (1) _____ (2)_____
Hep B (1) _____ (2)_____ (3) _____
Menactra _____
PCV _____
Tuberculin Test _____
Lead Screening Level _____
Chest x-ray _____

ARE THERE ANY FACTORS WHICH MAY PLACE THIS CHILD AT RISK FOR SCHOOL PROBLEMS? YES_____ NO _____

Is this child able to participate in all physical education activities? _____
If no, please state limitation and diagnosis _____
Recommendation for follow-up _____

******* NOT VALID WITHOUT PHYSICIAN'S STAMP ********

_____
Physician's Signature

HEALTH HISTORY – FOR NEW ENTRANTS AND TO UPDATE HEALTH HISTORY RECORD

TO PARENTS:

Please fill in and return the completed form to the pupil's classroom teacher or school nurse.

DISEASES	DATE	DISEASES	DATE	DISEASES	DATE
Anemia		German Measles		Scarlet Fever	
Asthma or Allergy		Measles		Tuberculosis	
Chicken Pox		Mononucleosis		Contacts with Tuberculosis	
Diabetes		Mumps		Whooping Cough	
Ear Problem		Nephritis		Other Illness	
Epilepsy		Pneumonia			
Frequent Colds, Sore Throats		Rheumatic Fever			

OPERATIONS	DATE	SERIOUS INJURIES	DATE
APPENDECTOMY			
TONSILLECTOMY			
OTHER			

Parent's/Guardian's Signature Date

Comments: