

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 Examination** \_\_\_\_\_

Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

BMI \_\_\_\_\_ Percentile \_\_\_\_\_

Eyes- vision with glasses R \_\_\_\_\_ L \_\_\_\_\_  
vision w/o glasses R \_\_\_\_\_ L \_\_\_\_\_

Hearing \_\_\_\_\_

Ears- Ooscopic \_\_\_\_\_

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 \_\_\_\_\_

Is this child able to participate in all physical education activities? \_\_\_\_\_

If no, please state limitation and diagnosis \_\_\_\_\_

Recommendation for follow-up \_\_\_\_\_

**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 \_\_\_\_\_

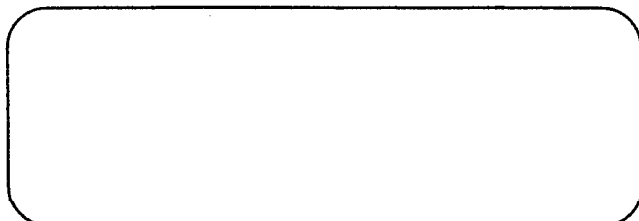
Tuberculin Test \_\_\_\_\_

Lead Screening Level \_\_\_\_\_

Chest x-ray \_\_\_\_\_

ARE THERE ANY FACTORS WHICH MAY PLACE THIS CHILD  
AT RISK FOR SCHOOL PROBLEMS? YES \_\_\_\_\_ NO \_\_\_\_\_

\*\*\*\*\* 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.

<b>DISEASES</b>	<b>DATE</b>	<b>DISEASES</b>	<b>DATE</b>	<b>DISEASES</b>	<b>DATE</b>
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			

<b>OPERATIONS</b>	<b>DATE</b>	<b>SERIOUS INJURIES</b>	<b>DATE</b>
APPENDECTOMY			
TONSILLECTOMY			
OTHER			

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date

**Comments:**

---



---



---



---