THE Intergenerational SCHOOLS
A COMMUNITY OF LIFELONG LEARNERS

School Entrance Physical Examination (**Completed by Physician**)
PLEASE GET IN YOUR IMMUNIZATIONS IN BY THE FIRST DAY OF SCHOOL

Name _____ Birth Date _____/_____/_____ School Year _____

Please complete the entire date including day, month, and year.

DTP/DTAP: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Polio: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
HIB: 1. _____ 2. _____ 3. _____ 4. _____
Hepatitis B: 1. _____ 2. _____ 3. _____
MMR: 1. _____ 2. _____ Hepatitis A: 1. _____ 2. _____
Varicella: 1. _____ 2. _____ Other: 1. _____ 2. _____

Physician may attach immunization record to this form instead of filling this section out.

Height: _____ Weight: _____ Blood Pressure: _____

Examination: Date: _____/_____/_____ Normal _____ Abnormal _____

Remarks and recommendations concerning abnormal findings: _____

_____

Restrictions: _____

Chronic Health Concerns: Asthma _____ Seizure Disorder _____ ADD/ADHD _____ Diabetes _____
Other: _____

Was child referred to a specialist for any reason? Explain _____

Special Tests (at discretion of physician)
Urinalysis _____ Hemoglobin _____ Lead _____ Sickle Cell _____
Tuberculin Test: (most recent) Date: _____ Type: _____ Results: Positive ____ Negative ____
Other _____

Hearing: Type of Test _____ Results: _____ Comments: _____
Vision: Acuity: Right – 20/ Left – 20/ Strabismus: Yes_____ No_____ Comments: _____

Medications:
Name of medication/Dosage/Frequency: _____
Reason for Medication: _____
(Please complete a separate form for medication administration if it is necessary for child to receive medication while in school)

Name of Physician (print) _____ Phone # (_____) _____-_____

Address _____ city _____ State _____ Zip _____

Based on examination consistent with EPSDT/Head Start/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Physician Signature: _____ Date: _____/_____/_____