

CAMDEN COUNTY HEALTH DEPARTMENT
Pre-School Physical Examination and Immunization Record

NAME _____ DATE OF BIRTH _____

PHYSICAL EXAMINATION RECORD

HEIGHT _____	WEIGHT _____
BLOOD PRESSURE _____	PULSE _____
VISION (R) _____ (L) _____	HEARING (R) _____ (L) _____
EYES _____	LUNGS _____
EARS, NOSE, THROAT _____	ABDOMEN _____
MOUTH AND TEETH _____	SKIN _____
NECK _____	GENITALS/HERNIA _____
HEART _____	EXTREMITIES _____
ALLERGIES _____	RESTRICTIONS FROM ACTIVITIES _____

RECOMMENDATIONS: _____

PRE-SCHOOL IMMUNIZATIONS

*** REQUIRED**

8 is recommended for pre-school entrance (will be required for KINDERGARTEN)

TYPE OF VACCINE	DOSE 1	DOSE 2	DOSE 3	BOOSTERS
1 DPT/DTaP	*	*	*	*
2 POLIO	*	*	*	
3 MMR	*			
4 VARICELLA (chicken pox)	* one dose or disease			
5 HIB	*			
6 INFLUENZA (before Dec. 31 st)	*			
7 PNEUMOCOCCAL	*			
8 HEPATITIS B				

DOCTOR'S NAME (PRINT) _____

DOCTOR'S ADDRESS _____ TELEPHONE _____

DOCTOR'S SIGNATURE _____ DATE OF EXAM _____