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. 31st)	*			
7 PNEUMOCOCCAL	*			
8 HEPATITIS B				

DOCTOR'S NAME (PRINT) _____

DOCTOR'S ADDRESS _____ *TELEPHONE* _____

DOCTOR'S SIGNATURE _____ *DATE OF EXAM* _____