Physician Certificate of Examination Form
(To be completed by a physician)
Please Print. Thank you.

Name: _____ Date of Birth: ____/____/____

Allergies_____

Current Medications: (List name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

Height: _____ Weight: _____ B/P:_____

Eyes: _____

Ears: _____ **Lead Level** (if indicated):_____

Nose: _____

Throat: _____ **Sickle Cell** (If indicated):_____

Chest: _____

Heart: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given: _____

Extremities: _____ Date Read: _____

Posture/Scoliosis: _____ Results: _____

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain: _____

  _____
- Please list any condition that should be considered in planning this child's school day:_____

  _____

Immunization Record: (Month/Day/Year)

DTaP:
1._____
2._____
3._____
4._____
5._____

Hepatitis B:
1._____
2._____
3._____

M.M.R:
1._____
2._____

IPV/OPV (please indicate):
1._____
2._____
3._____
4._____

Varicella:
1._____
2._____

Hepatitis A:
1._____
2._____

Pertussis/Tdap:
1._____

Meningitis/MCV4:
1._____
2._____

Meningococcal B:
1. _____
2._____

HPV:
1._____
2._____
3._____

Date of Chicken Pox Disease: _____

Physician completing this form: _____

Please Print/Stamp

Physician's Signature: _____Date: _____