Physician Certificate of Examination Form

(To be completed by a physician) Please Print!

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: _____

- Does this child have any health condition that would be hazardous either to the child or to the other children in a group setting as a result of participation in normal activities (including sports)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

_____

Immunization Record: (Month/Day/Year)

DtaP/Tdap
1. _____
2. _____
3. _____
4. _____
5. _____

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

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

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

Varicella:
1. _____
2. _____

Hepatitis A:
1. _____
2. _____

Pertussis:
1. _____

Meningitis:
1. _____
2. _____

HPV:
1. _____
2. _____
3. _____

Physician Completing this form: _____

Please Print/Stamp

Physician's Signature: _____ Date: _____