

**OFFICE OF THE SCHOOL NURSE  
SAINT PATRICK SCHOOL  
PHYSICAL EXAMINATION**

Phone (603) 635-2941 Fax (603) 635-9800

To be filled out by your DOCTOR

NAME OF CHILD \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DATE OF PHYSICAL EXAMINATION \_\_\_\_\_

Vision Screening _____	Heart _____
Hearing Screening _____	Lungs _____
Nose & Throat _____	Abdomen _____
Glands _____	Urine _____
Teeth _____	Blood _____
Blood Pressure _____	Hernia _____
Height _____	Weight _____
Skin _____	Orthopedic _____

HISTORY OF COMMUNICABLE DISEASES: PLEASE LIST YEAR  
 Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Rubella \_\_\_\_\_ Scarlet Fever \_\_\_\_\_  
 Mumps \_\_\_\_\_ Diphtheria \_\_\_\_\_ Other \_\_\_\_\_

Does this child have any allergies? \_\_\_\_\_

**IMMUNIZATIONS: PLEASE LIST DAY / MONTH / YEAR**

VACCINE	DATE GIVEN	VACCINE	DATE GIVEN
DPT 1	_____	OPV/IPV 1	_____
DPT 2	_____	OPV/IPV 2	_____
DPT 3	_____	OPV/IPV 3	_____
DPT/DTaP 4	_____	OPV/IPV 4	_____
DPT/DTaP 5	_____	MMR 1	_____
Hib 1	_____	MMR 2	_____
Hib 2	_____	Varicella	_____
Hib 3	_____	HEP B 1	_____
Hib 4	_____	HEP B 2	_____
Lead/EP dates	_____	HEP B 3	_____
Varivax	_____	Influenza	_____
TB test	_____	Other	_____

**This child is physically capable of carrying a full school program and may participate in physical education: YES \_\_\_\_\_ NO \_\_\_\_\_**

**Exceptions: \_\_\_\_\_**

**Does this child require an EpiPen for allergic reactions YES \_\_\_\_\_ NO \_\_\_\_\_**

**Is this child on daily medication at home or school YES \_\_\_\_\_ NO \_\_\_\_\_**

**If yes, please list medication and reason for taking \_\_\_\_\_**

**PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**PHYSICIAN'S STAMP \_\_\_\_\_ Tel. # \_\_\_\_\_**