

Oceanside Union Free School District
Oceanside, NY 11572

Physical Examination

School # _____

Grade _____

The law requires that all pupils in public schools be examined by a physician upon entrance to each school, and upon entering kindergarten, second, fourth, seventh, and tenth grades. Examination by the family physician is recommended annually.

Please return the completed form to the pupil's classroom teacher when the pupil is examined by the family physician, physician assistant, or nurse practitioner.

Child's Name _____

Date of Examination _____

Date of Birth _____

Height _____ Weight _____

BMI _____ Percentile _____

Eyes- vision with glasses R _____ L _____
vision w/o glasses R _____ L _____

Hearing _____

Ears- Ooscopic _____

Genito-Urinary _____

Urinalysis _____

Heart _____ Blood Pressure _____

Lungs _____

Lymph Nodes _____

Nervous System- Specify
if epileptic _____

Nose _____

Nutrition _____

Orthopedic _____

Including Scoliosis _____

Skin _____

Speech _____

Thyroid _____

Tonsils _____

Allergies _____

Other _____

CURRENT MEDICATIONS AND TREATMENTS _____

MEDICAL/SURGICAL HISTORY _____

Explanation _____

INITIAL IMMUNIZATIONS AND BOOSTERS

DPT (1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

DT _____

DTap _____

Tdap _____

Polio (TOPV) Oral/IVP

(1) _____ (4) _____

(2) _____ (5) _____

(3) _____ (6) _____

Varicella Disease _____

Varivax (1) _____ (2) _____

MMR (1) _____ (2) _____

or

Measles _____

Mumps _____

Rubella _____

HIB (1) _____ (2) _____ (3) _____

Hep A (1) _____ (2) _____

Hep B (1) _____ (2) _____ (3) _____

Menactra _____

PCV _____

Tuberculin Test _____

Lead Screening Level _____

Chest x-ray _____

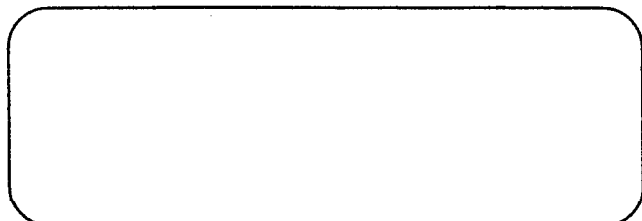
ARE THERE ANY FACTORS WHICH MAY PLACE THIS CHILD
AT RISK FOR SCHOOL PROBLEMS? YES _____ NO _____

Is this child able to participate in all physical education activities? _____

If no, please state limitation and diagnosis _____

Recommendation for follow-up _____

***** NOT VALID WITHOUT PHYSICIAN'S STAMP *****



Physician's Signature

**HEALTH HISTORY – FOR NEW ENTRANTS
AND TO UPDATE HEALTH HISTORY RECORD**

TO PARENTS:

Please fill in and return the completed form to the pupil's classroom teacher or school nurse.

DISEASES	DATE	DISEASES	DATE	DISEASES	DATE
Anemia		German Measles		Scarlet Fever	
Asthma or Allergy		Measles		Tuberculosis	
Chicken Pox		Mononucleosis		Contacts with Tuberculosis	
Diabetes		Mumps		Whooping Cough	
Ear Problem		Nephritis		Other Illness	
Epilepsy		Pneumonia			
Frequent Colds, Sore Throats		Rheumatic Fever			

OPERATIONS	DATE	SERIOUS INJURIES	DATE
APPENDECTOMY			
TONSILLECTOMY			
OTHER			

Parent's/Guardian's Signature

Date

Comments:
