SCHOOL ENTRANCE PHYSICAL EXAMINATION
(TO BE COMPLETED BY PHYSICIAN)

Name:_____ **Date of Birth**:_____ **Grade**_____

Immunization Information

Please complete using the date/month/year

DTaP:	**1.**_____	**2.**_____	**3.**_____	**4.**_____	**5.**_____				
Td:	**1.**_____	**2.**_____	**3.**_____	**4.**_____	**5.**_____				
IPV/OPV:	**1.**_____	**2.**_____	**3.**_____	**4.**_____	**5.**_____				
HIB:	**1.**_____	**2.**_____	**3.**_____	**4.**_____					
Hepatitis B:	**1.**_____	**2.**_____	**3.**_____						
MMR:	**1.**_____	**2.**_____	**Hepatitis A:**	**1.**_____	**2.**_____				
Varicella:	**1.**_____	**2.**_____	**Meningococcal**	**1.**_____ _	**2.**_____				
Pneumococcal:	**1.**_____	**2.**_____	**3.**_____	**4.**_____					
Influenza: _____			**Other:**_____						

Exam Date_____ **Normal**_____ **Abnormal findings**_____

Height: _____ **Weight:**_____

General Dental Health _____

Hearing: Right:_____ Left:_____

Vision: Acuity: Right 20/_____ Left 20/_____

Strabismus: Yes___ No___ Comments_____

Tuberculin test (most recent): Date _____ Results: Positive_____ Negative_____

Chronic Health Concerns: **Asthma:** _____ **Seizure Disorder:** _____ **ADD/ADHD:** _____
Diabetes: _____ **Speech therapy:** _____ **Ear Infections:** _____

Other: _____

Was the child referred to any specialists? _____

Restrictions:

Medications: Name/dosage/frequency:

Please complete the school's forms for medication administration if it is necessary for the child to receive prescription or over-the-counter medication in school

Physician name (print): _____ **Phone:** _____

Address: _____**City/State/Zip:** _____

Based on examination consistent with EPSDT/Headstart/AAP guidelines, I certify this child to be in suitable condition for enrollment in school.

Physician signature: _____ **Date:** _____