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Previously Submitted

IMMUNIZATIONS

Name _____
 DOB _____

	1 ST	2 ND	3 RD	4 TH	5 TH
DTaP					
IPV					
HIB					
PNEUMOCOCCAL					
HEP B					
MMR					
VARIVAX					
OTHER					

LEAD	
DATE	RESULT

MEDICAL HISTORY

1. Significant Medical/Surgical History: _____
2. Allergies: _____
3. Medications taken regularly: _____
4. Medication to be given in school: Name: _____
 Dosage/Time: _____
5. Modification/Restriction in physical education: _____

PHYSICAL EXAM

HEIGHT _____ WEIGHT _____ B.P. _____

	NORMAL	ABNORMAL	COMMENTS
GENERAL APPEARANCE			
SKIN			
HEAD			
EYES			
EARS			
NOSE & THROAT			
NECK			
LUNGS			
HEART			
ABDOMEN			
GENITALIA			
MUSCULOSKELETAL			
SCOLIOSIS	NEGATIVE	POSITIVE	
NEUROLOGICAL			

- Physically qualified for participation in all sports
- Sports participation limited to _____
- Physically qualified for employment

I have performed a complete physical examination on this child. I certify that there have been no changes in his/her health status since the above examination.

Provider's Name _____

Provider's Signature _____

Date _____