FAIR HAVEN PUBLIC SCHOOLS

Physical Examination Report for New Students

_____
Examination Date

Child's Name _____ Male ___ Female ___ Birth Date _____ _____ _____
Month Day Year

Address _____ Phone _____

TO BE COMPLETED BY FAMILY PHYSICIAN:

Height _____ Weight _____ B.P. _____ Pulse _____

Eyes: Right _____ Ears Right _____

Eyes: Left _____ Ears Left _____

Nose _____ Abdomen _____

Teeth _____ Genito Urinary _____

Speech _____ Extremities _____

Throat _____ Orthopedic _____

Neck _____ Posture _____

Heart _____ Skin _____

Lungs _____ Nutrition _____

Do you prescribe any restrictions on school-related physical activity: _____ _____ If yes, list your recommendations on reverse side.
Yes No

IMMUNIZATIONS: Date Administered (month, day, year)

D.P.T. Series 1. _____ 2. _____ 3. _____

D.P.T. Booster 4. _____ on or after 4th birthday 5._____

Hib 1. _____ 2. _____ 3. _____ 4. _____

MMR Vaccine 1. _____ on or after 1st birthday 2. _____ (Booster)

Mumps Vaccine _____ Rubella Vaccine _____

Poliomyelitis Vaccine 1. _____ 2. _____ 3. _____

Poliomyelitis Booster 4. _____ on or after 4th birthday 5. _____

Hepatitis A 1. _____ 2. _____

Hepatitis B 1. _____ 2. _____ 3. _____

Varicella Vaccine 1. _____ on or after 1st birthday 2. _____ (Booster)

Pneu.Cong.Vaccine 1. _____ 2. _____ 3. _____ 4. _____

Influenza _____

Mantoux Skin Test _____ Results: _____

Other_____

Physician's Signature/ Stamp/ Date _____

NOTE:Information reported on this form should be reflective of a physical exam conducted within one (1) year of admission.

Revised: 1/08