RSU 40/MSAD 40 PHYSICAL EXAMINATION FORM

Student Name: _____ Date of Birth: _____ Grade: _____

Address: _____ School: _____

Parent's Name: _____

PHYSICAL EXAMINATION SHALL INCLUDE THE FOLLOWING:

Urinalysis: _____ Skin: _____ Scalp: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____

Teeth and oral hygiene: _____

Neck (thyroid, lymph nodes): _____

Blood Pressure: Systolic: _____ Diastolic: _____ Pulse: _____

Nutrition: _____ Abdomen: _____

Hernia: _____ Lungs: _____ TB Test: Positive: _____
Negative: _____

Genitalia (Males): _____ If positive, Chest X-Ray: _____

Menstruation (Female): _____ Any history of: Allergy: _____
Seizures: _____

Height: _____ Weight: _____ Convulsions: _____

Lead Test Results: _____

Posture:_____ Bones & Joints: _____

Remarks: _____

IMMUNIZATIONS: (Please give all dates – month, day and year)

DPT/DTaP	OPV/IPV	MMR	VARICELLA	Hep A
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____			
_____	_____	HIB	HEP B	Meningococcal
_____		_____	_____	_____
	Tdap	_____	_____	
	_____	_____	_____	OTHER
		_____		_____

PLEASE RETURN THIS FORM TO:
RSU 40 SCHOOL HEALTH SERVICES
320 Manktown Road
Waldoboro, ME 04572
OR FAX TO: 207-832-8256

Signed: _____
(Physician)

Date: _____