

Sagaponack Common School
P. O. Box 1500
Sagaponack, NY 11962
Telephone (631) 537-0651
Fax (631) 537-2342

PHYSICAL EXAMINATION FORM

Name: _____
(Last) (First) (Middle)

Address: _____

Height: _____ Weight: _____
Eyes: _____ Ears (Otosopic): _____
Lymph nodes: _____ Thyroid: _____
Nose: _____
Tonsils: _____ Teeth: _____
Heart: _____ Lungs: _____
Hernia: _____

Orthopedic Problem: Structural: _____
Posture: _____
Feet: _____

Scoliosis: _____

Skin: _____

Genito-Urinary: _____

Nervous System: _____

Speech: _____

Nutrition: _____

Blood Pressure: _____ (all students)

Name of any Defect, Allergy, Disability: _____

Teacher: _____

School: _____ Grade: _____

Is this child taking medication on a regular basis? Yes No

If yes, please provide name of drug, dosage and frequency

Is this child able to participate in physical education? Yes No

If not, what restrictions?

If this student is a new entrant, a complete immunization schedule is required!
Does this child need an immunization of any type? Yes No

List date of latest immunization or booster: **THIS IS NOT AN IMMUNIZATION RECORD UNLESS ALL DATES ARE RECORDED.**

Measles: _____ DPT: _____
Mumps: _____ D-T: _____
Rubella: _____ Sabin (TOBV): _____
MMR #1: _____ MMR#2: _____ Varivax: _____
Hepatitis B#1: _____ Hepatitis B#2: _____ Hepatitis B#3: _____
Chest X-ray: _____ Tuberculin Test: _____

Other: _____

Physician's Name (print): _____

Signature: _____

Physician's Address: _____

Telephone: _____ Date of Exam: _____

Other Comments: _____
