Please return to: School Nurse

Indian River Central School District
Physical by Family Physician

Child's Name _____ Sex _____ Date of Birth _____

Parent's Name _____ Phone # _____

Address _____

Medical Examination

Eyes _____

Ears (otoscopic) _____

Lymph Nodes _____

Thyroid _____

Nose _____

Tonsils _____

Teeth _____

Heart _____

Lungs _____

Hernia _____

Genito - Urinary _____

Orthopedic

Structural (scoliosis) _____

Posture _____

Feet _____

Skin _____

Seizure Disorder _____

Nervous System _____

Speech _____

Nutrition _____

Other _____

Immunizations

Oral Polio _____ _____ _____

Booster _____ _____ _____

Measles #1 _____ #2 _____

German Measles _____

Mumps _____

MMR #1 _____ #2 _____

Diphtheria - Tetanus - Pertussis

_____ _____ _____

Boosters _____ _____ _____

Tetanus - Diphtheria _____

Hib _____

Tuberculin test _____

Results _____

Height _____

Weight _____

Daily Medications _____

Allergies _____

Use reverse side for important past history.

_____
Signature of Physician

_____
Date of Examination

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