PRIVATE PHYSICIAN'S EXAMINATION REPORT

Student's Name_____ DOB_____

Examining Physician_____
(Print)

Date of Exam _____ Physician's Phone Number_____

Height_____ Weight_____ Blood Pressure_____

Scalp, Head, Neck_____

Eyes_____ Last Eye Exam_____

Ears_____ Last Hearing Exam_____

Nose_____

Mouth and Throat_____

Chest and Lungs_____

Heart_____

Abdomen, Hernia_____

Genitals_____

Extremities_____

Skin_____

Posture, Gait, Spine_____

Coordination_____

Blood Pressure_____

Restrictions_____

Referral Needed YES_____ NO____

Immunizations_____***Please attach shot record***

**6th grade students: Meningococcal vaccine Date_____

Tdap Date_____

Physician's Signature _____