BERLIN TOWNSHIP SCHOOLS
PHYSICAL EXAMINATION

Name: _____ Exam Date: _____ Age: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____ Home Phone: _____
School: _____ Grade: _____ Sex: _____
Physician: _____ Phone: _____ Fax: _____
Address: _____ City/State/Zip: _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.
Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N
Hearing : R_____ L _____

	Normal	Abnormal Findings	Comments
Ears			
Eyes/Sclera/Pupils			
Lymph Glands			
Thyroid			
Nose/Mouth-Teeth/Throat			
Heart: Murmurs/Rhythm /*rate			
Lungs			
Abdomen			
Hernia	No	Yes/Possible	
Genito-Urinary			
Orthopedic : Structural Posture Feet			
Scoliosis			
Skin			
Nutrition			
Neurological			
Speech			
Other			
GENERAL APPEARANCE			

Immunizations/Dates:
DPT / DTaP: 1._____ 2. _____ 3._____ 4._____ 5._____
OPV / IPV: 1._____ 2._____ 3. _____ 4. _____ 5._____
MMR: 1. _____ 2._____
HEPATITIS B: 1. _____ 2._____ 3._____
VARIVAX: 1._____ 2._____ or Hx OF DISEASE: _____
HIB: 1._____ 2._____ 3._____ 4._____ 5. _____
PCV: 1._____ 2._____ 3._____ 4._____ 5. _____
MANTOUX: 1. _____ RESULTS _____ DATE READ _____
2. _____ RESULTS _____ DATE READ _____
INFLUENZA VACCINE: _____
OTHER: _____

OVER

BERLIN TOWNSHIP SCHOOLS

STUDENT HISTORY	YES	NO	IF YES, EXPLAIN
A chronic or ongoing illness (such as diabetes, asthma, seizures)?			
An inhaler or other prescription medicine to control this chronic disease?			
Any prescribed or over the counter medication he/she takes on a regular basis?			
Any allergies to medication?			
Any allergies to bee stings, pollen, latex, foods or environmental allergens. (If more than one allergy, please explain reaction to each) If yes, check type of reaction: ___Rash ___Hives ___Breathing or other anaphylactic reation? Any medication/Epi-pen taken for allergy symptoms?			

List all medications here:

Medication Name	Dosage	Frequency

Recent: 1. Surgeries _____

2. Injuries _____

Additional Observations:

CLEARANCE:

A. Student may participate fully in THE PHYSICAL EDUCATION PROGRAM: YES NO

1. EXPLAIN ANY LIMITATIONS:

_____

_____

Physician's/Provider's Signature: _____

Date: _____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider_____

School Physician_____

___MD___DO___NP___PA

TELEPHONE NUMBER: _____

FAX: _____

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