CHILD'S NAME: _____

PHYSICIAN REPORT

IMMUNIZATIONS

	Date	Date	Date	Date	Date
DPT					
Td					
Polio Sabin (Tri)					
MMR					
Hep B					
Varivax					
Hib					
OTHER					

SCREENING TESTS

	Date	Result	
Muscle Balance			
Farsightedness			
Color			
Distance Acuity		RIGHT	LEFT
HEARING			

TUBERCULIN	Date	Test	Result

PHYSICAL ASSESSMENT

Check one:

☐ Entirely within normal limits

☐ Abnormalities as follows:

Is there any reason why the student cannot carry out a full program of school work?

☐ Yes ☐ No

Date _____

Signature of Examining Physician _____