

**Physician Certificate of Examination Form****(To be completed by a physician)****Please Print!**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies \_\_\_\_\_

**Current Medications: (List name, dosage, and time)**

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

2. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_

Eyes: \_\_\_\_\_

Ears: \_\_\_\_\_

**Lead Level** (if indicated): \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

**Sickle Cell** (If indicated): \_\_\_\_\_

Chest: \_\_\_\_\_

Heart: \_\_\_\_\_

**P.P.D.:** (Recommended)

Hernia: \_\_\_\_\_

Date Given: \_\_\_\_\_

Extremities: \_\_\_\_\_

Date Read: \_\_\_\_\_

Posture/Scoliosis: \_\_\_\_\_

Results: \_\_\_\_\_

- Physically fit to participate in all physical education programs? Yes No

If "No" please explain: \_\_\_\_\_

- Please list any condition that should be considered in planning this child's school day: \_\_\_\_\_

**Immunization Record: (Month/Day/Year)**

DtaP/Tdap:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Hepatitis B:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Hepatitis A:

1. \_\_\_\_\_

2. \_\_\_\_\_

Pertussis:

1. \_\_\_\_\_

Meningitis:

1. \_\_\_\_\_

2. \_\_\_\_\_

IPV (please indicate if OPV)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

Varicella:

1. \_\_\_\_\_

2. \_\_\_\_\_

HPV:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Physician Completing this form: \_\_\_\_\_

**Please Print/Stamp**

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_