Mary Bray School
Tracy Heckers, RN
931-7807

MOUNT EPHRAIM PUBLIC SCHOOLS
PHYSICAL EXAMINATION RECORD

R. W. Kershaw School
Elisa Keane, RN
931-1634

Child's Name ____
Last First Date of Birth

Parent(s)/Guardian's Name ____
Last First

Record of Immunizations

DPT-1st _______ 2nd _________ 3rd _________ 4th ________ 5th ______ Tdap ________

Polio-1st ____________ 2nd ________ 3rd ________ 4th _________ Booster _____

Measles/MMR- 1st ______ 2nd _______ HIB- 1st _________ 2nd ________ 3rd ________

Hepatitis B- 1st ____________ 2nd ________ 3rd ________ Varicella _______ _________

Influenza _____ ______ Pneumonia _______ Meningococcal _______ Mantoux _______ Result _____

Health History

Chicken Pox ______________________

Eczema/Psoriasis __________________

Ear Infections ______________________

Rheumatic Fever ___________________

Seizure Disorder ___________________

Asthma ___________________________

Sinusitis ___________________________

Diabetes ___________________________

Allergies ___________________________

Congenital Defects ________________________

History of Heart Trouble ___________________

History of Lung Trouble____________________

Family History of Diabetes__________________

Other _____________________________________

Operations _________________________________

Hospitalizations _____________________________

Under Doctor's Care _________________________

Doctor's Examination

Height _______ Weight ____________

Posture ___________________________

Extremities ________________________

Nutrition __________________________

Skin ______________________________

Teeth _____________________________

Throat ____________________________

Ears ______________________________

Eyes ______________________________

Blood Pressure ________________________

Feet _________________________________

Heart ________________________________

Nervous System _______________________

Lungs ________________________________

Abdomen _____________________________

Hernia _______________________________

Genitals ______________________________

General Condition ______________________

Restrictions ___________________________

______________________ ______________________________
Date Physician's Signature Physician's stamp