This side to be completed by physician/approved healthcare provider

Name _____

Immunization: Record date of each dose received (mm/dd/yy)										
	1st	2nd	3rd	4th	5th	6th		1st	2nd	3rd
DTaP (Diphtheria, pertussis, tetnus)							MMR (Measles, Mumps, Rubella)			
Td/DT/Tdap							Hep B (Hepatitis B)			
OPV or IPV (Polio)							Varicella (Chicken Pox)			
HIB (Hemophilus influenza B)							Hep A			

The above immunizations have been verified by the following: _____

Signature of physician or other qualified person

PHYSICAL EXAMINATION: TO BE COMPLETED BY APPROVED HEALTH CARE PROVIDER.

Height _____ Weight _____ Hgb or Het _____

Pulse _____ Blood Pressure _____ Lead _____

Urinalysis _____ Sickle Cell _____ TB _____

Code Each Item as Follows: 0=No sig. findings 1=Significant findings	Code	Description of Findings
General Appearnace		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional Evaluation - Results _____
2. Development: Type of screen _____ Results _____
3. Speech: Type of screen _____ Results _____
4. Hearing: Type of screen _____ Results _____ Date of last screen _____
5. Visioin: Type of screen _____ Results _____ Date of last screen _____

Significant Assessment Findings:

Anticipatory Guidance: (circle those discussed)

1. Safety
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

Recommendations: (to parents, teachers -- include any referrals)

Follow Up:

RECOMMENDATIONS FOR PHYSICAL EDUCATION:

Full program _____ Restricted (explain) _____

No participation (explain) _____

Additional Information may be attached.

_____ _____

Date Signature of Physician or Nurse approved to perform health assessments