Genoa City Jt. 2 Student Physical Form

Child's Name Birthdate Age Sex

Parent/Guardian Name Address Phone

Immunization History

DTP	_____	_____	_____	_____	_____
Tdap	_____				
Polio	_____	_____	_____	_____	_____
Measles	_____	_____			
Rubella	_____	_____			
Mumps	_____	_____			
Hepatitis B	_____	_____	_____		
Varicella	_____	_____			

TB Skin Test (Optional)_____

To be filled out by the Physician:

Height_____ Weight_____ B.P._____ Pulse_____

Eyes: Right_____Left_____ Vision: Right_____Left_____Ears: Right_____ Left_____

Allergies (list)_____

Nose_____	Mouth/Throat_____	Neck_____
Heart_____	Lymph Glands_____	Lungs_____
Hernia_____	Abdomen_____	Skin_____
Scalp_____	Neuro-Muscular____	Posture____

What emotional problems, if any, should be watched_____

Any limitation of activities? No_____ Yes_____
If yes, please
explain:_____

Any condition that may result in an emergency? No____Yes____
If yes, please
explain_____

Is the student on medication we should be aware of? No___Yes___
If yes, please list type and dosage
_____

Physician's Signature_____ Date_____

Address_____Phone _____