Sherburne-Earlville Elementary School • Sherburne, New York 13460

PHYSICAL EXAMINATION FORM

(TO BE COMPLETED BY EXAMINING PHYSICIAN)

Student Name_____ **DOB**_____

Height _____ **Weight**_____ **BP**_____ **UA**_____ **Hct or Hgb**_____

(NOT MANDATORY)

	NORMAL	DEFECT	DESCRIPTION	TREATMENT
Eyes				
Ears				
Nose				
Throat				
Thyroid				
Lymph Nodes				
Heart				
Lungs				
Abdomen				
Genitals				
Posture				
Extremities				
Nervous System				
Skin				
Nutrition				
Musculature				
Teeth				
Speech				
Scoliosis				
Other				

Vision (Eye Appt. not required) **R. Eye**_____ **L. Eye**_____ **With Cor. lenses**_____ **W/O Cor. lenses** _____

Has this child had chicken pox (varicella) or varicella vaccine? If so, please enter date_____

Immunizations given today:_____

Findings or Recommendations: _____

REFERRALS:	**YES**	**NO**
Immediate Medical	❑	❑
Dental	❑	❑
Psychological	❑	❑

❑ **Limited Activity**_____ ❑ **Unlimited Activity**

Please sign and date below.

Examinimg Physician:_____

Signature Date