FAIRFIELD COMMUNITY SCHOOLS – Health Services
Immunization Record and Physical Examination

NAME_____ **BIRTHDATE**_____ **GENDER**_____

PARENTS/GUARDIAN_____ **PHONE**_____

SCHOOL (circle) BES FJSHS MEMS NPES GRADE (circle) P K 1 2 3 4 5 6 7 8 9 10 11 12

** BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY **

IMMUNIZATION RECORD

Please attach a copy of the immunization record.

Does the child have history of Chickenpox disease? YES NO If YES, please provide the month and year on the immunization record.

PHYSICAL EXAMINATION

Height _____ inches Weight _____ lbs. LABORATORY: Hct/Hgb (optional)_____
Body Mass Index_____ Urinalysis_____

Vision: Right 20/ _____ Left 20/_____ Wears glasses? YES NO Wears Contacts? YES NO
Hearing: Right_____ Left_____

Blood Pressure _____/____

Head_____
Eyes_____
Ears_____
Nose_____
Throat_____
Neck_____
Lymph _____
Marfan's syndrome stigmata YES NO
Other_____

Heart_____
Lungs_____
Back_____
Scoliosis: YES NO Monitor
Abdomen_____
Neuro/reflexes_____
Hernia_____
Genitalia_____
Congenital abnormalities_____

History of heart murmur and/or cardiac problems? If yes, please explain_____

Physical activity restrictions? YES NO If yes, please specify_____
Sports participation: ____ Cleared
____ Cleared after evaluation for _____
____ Not cleared due to _____

Allergies: ___ Bee/insect sting (please list)_____
___ Food (please list) _____
___ Medication (please list) _____
___ Other (please list) _____
Do any of the allergies require Epinephrine? YES NO

Dietary Restrictions? YES NO If yes, please specify restrictions_____

Known Medical Problems: ___Asthma ___ Seizures ___Diabetes ___Hypoglycemia
___Other (Please List): _____

Does this student take medication regularly: YES NO If YES, please list medication, dosage and frequency_____

Describe any health issues the school needs to be aware of: _____

Date of Exam | Office Phone Number | Health Care Provider Signature

Print Name of Provider Signature

Use reverse side for additional information 5/2018 dlm