Sagaponack Common School
P. O. Box 1500
Sagaponack, NY 11962
Telephone (631) 537-0651
Fax (631) 537-2342

PHYSICAL EXAMINATION FORM

Name: _____
(Last) (First) (Middle)
Address: _____

Height: _____ Weight: _____
Eyes: _____ Ears (Otoscopic): _____
Lymph nodes: _____ Thyroid: _____
Nose: _____
Tonsils: _____ Teeth: _____
Heart: _____ Lungs: _____
Hernia: _____

Orthopedic Problem: Structural: _____
Posture: _____
Feet: _____
Scoliosis: _____

Skin: _____

Genito-Urinary: _____

Nervous System: _____

Speech: _____

Nutrition: _____

Blood Pressure: _____ (all students)

Name of any Defect, Allergy, Disability: _____

_____

Teacher: _____

School: _____ Grade: _____

Is this child taking medication on a regular basis? ☐ Yes ☐ No
_____
If yes, please provide name of drug, dosage and frequency

Is this child able to participate in physical education? ☐ Yes ☐ No
_____
If not, what restrictions?

If this student is a new entrant, a complete immunization schedule is required!
Does this child need an immunization of any type? ☐ Yes ☐ No

List date of latest immunization or booster: **THIS IS NOT AN IMMUNIZATION RECORD UNLESS ALL DATES ARE RECORDED.**

Measles: _____ DPT: _____
Mumps: _____ D-T: _____
Rubella: _____ Sabin (TOBV): _____
MMR #1: _____ MMR#2: _____ Varivax: _____
Hepatitis B#1: _____ Hepatitis B#2: _____ Hepatitis B#3: _____
Chest X-ray: _____ Tuberculin Test: _____

Other: _____

Physician's Name (print): _____

Signature: _____

Physician's Address: _____

Telephone: _____ Date of Exam: _____

Other Comments: _____

_____