

RED CREEK CENTRAL SCHOOL

Red Creek, NY 13143

Physician Report of School Child

Name of Child _____ D. O. B. _____ Age _____ Date of Examination _____

SIGNIFICANT PROBLEMS:

Medical Yes ___ No ___ If yes, describe _____

Dental Yes ___ No ___ If yes, describe _____

Development Yes ___ No ___ If yes, describe _____

Restrictions Yes ___ No ___ If yes, describe _____

Recommendations to school: _____

Medication required: _____

Record of Any Testing

Immunizations Given

Date

Test Results Date

DPT, DT₁ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

IPV/OPV 1 _____ 2 _____ 3 _____ 4 _____

MMR 1 _____ 2 _____

HEP. B 1 _____ 2 _____ 3 _____

VARICELLA _____

Height: ___ **Weight:** ___ **B.P.** ___ / ___

HIB 1 _____ 2 _____ 3 _____ 4 _____

SCOLIOSIS: P _____ N _____

OTHER 1 _____ 2 _____ 3 _____ 4 _____

Any significant health history (i.e., serious illnesses or injuries, premature, birth defects, etc.)

Physician's Name (please print) Physician's signature Date