PRIVATE PHYSICIAN'S EXAMINATION REPORT

Student's Name____ DOB____________________

Examining Physician____
(Print)

Date of Exam ____________________ Physician's Phone Number____________________

Height__________________ Weight________________ Blood Pressure________________

Scalp, Head, Neck____

Eyes___________________________ Last Eye Exam______________________________

Ears___________________________ Last Hearing Exam___________________________

Nose____

Mouth and Throat____

Chest and Lungs____

Heart____

Abdomen, Hernia____

Genitals____

Extremities____

Skin____

Posture, Gait, Spine____

Coordination____

Blood Pressure____

Restrictions____

Referral Needed YES_____ NO____

Immunizations_______ ***Please attach shot record***

**6th grade students: Meningococcal vaccine Date________

Tdap Date________

Physician's Signature ____