



MEDICAL EXAMINATION RECORD

Name: _____ Date of Birth: _____

Address: _____ Date of Exam: _____

Height: _____

Code: Normal - X Defect - 0

Weight: _____

Nose-Throat: _____

B/P: _____

Heart: _____

Vision: Right: _____

Abdomen: _____

Left: _____

Hernia: _____

Glasses Recommended: _____

Genito-Urinary: _____

Ears: Right: _____

Lymph Glands: _____

Left: _____

Skeletal/

Hearing: _____

Extremities: _____

Past Disease History (incl. Chicken pox)

Scoliosis Check: _____

Skin: _____

Scalp: _____

Operation/Injuries: _____

Neurological: _____

Allergies: _____

Any limitations from physical activities? _____

Is this child on medication/why? _____

IMMUNIZATION RECORD

VACCINES	1 ST DOSE	2 ND DOSE	3 RD DOSE	4 TH DOSE	5 TH DOSE	6 TH DOSE
DPT/DTAP/TD/Tdap	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
Measles (Live)	_____	_____	_____	_____	_____	_____
Rotavirus	_____	_____	_____	_____	_____	_____
Hepatitis A	_____	_____	_____	_____	_____	_____
Hib	_____	_____	_____	_____	_____	_____
Hep B Vaccine	_____	_____	_____	_____	_____	_____
TB Test (Type)	_____	_____	_____	_____	_____	_____
Meningococcal	_____	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____	_____
Pneumococcal	_____	_____	_____	_____	_____	_____
Influenza	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

PHYSICIANS NAME: _____ SIGNATURE: _____

PHYSICIANS ADDRESS: _____