OFFICE OF THE SCHOOL NURSE
PELHAM SCHOOL DISTRICT
PHYSICAL EXAMINATION

Phone (603) 635-2321x2011 Fax (603) 635-2369

To be filled out by your DOCTOR

NAME OF CHILD_____DATE OF BIRTH_____

DATE OF PHYSICAL EXAMINATION_____

Vision Screening_____ Heart_____
Hearing Screening_____ Lungs_____
Nose & Throat_____ Abdomen_____
Glands_____ Urine_____
Teeth_____ Blood_____
Blood Pressure_____ Hernia_____
Height _____Weight_____
Skin _____ Orthopedic _____
HISTORY OF COMMUNICABLE DISEASES: PLEASE LIST YEAR
Measles_____ Chicken Pox_____ Rubella_____ Scarlet Fever_____
Mumps_____Diphtheria_____Other_____
Does this child have any allergies? _____

IMMUNIZATIONS: PLEASE LIST DAY / MONTH/ YEAR

VACCINE	**DATE GIVEN**	**VACCINE**	**DATE GIVEN**
DPT 1	_____	OPV/IPV 1	_____
DPT 2	_____	OPV/IPV 2	_____
DPT 3	_____	OPV/IPV 3	_____
DPT/DTaP 4	_____	OPV/IPV 4	_____
DPT/DTaP 5	_____	MMR 1	_____
Hib 1	_____	MMR 2	_____
Hib 2	_____	Varicella	_____
Hib 3	_____	HEP B 1	_____
Hib 4	_____	HEP B 2	_____
Lead/EP dates	_____	HEP B 3	_____
Varivax	_____	Influenza	_____
TB test	_____	Other	_____

This child is physically capable of carrying a full school program and may participate in physical education: YES_____NO_____
Exceptions:_____
Does this child require an EpiPen for allergic reactions YES_____NO_____
Is this child on daily medication at home or school YES_____ NO_____
If yes, please list medication and reason for taking_____
_____

PHYSICIAN'S SIGNATURE_____DATE_____

PHYSICIAN'S STAMP_____Tel. #_____