Raymond School District Policy – JLCA-R*

FAMILY PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

TO BE RESCINDED

Name_____

School_____

Birth Date_____ Grade_____

PHYSICAL EXAMINATION, IMMUNIZATIONS, AND TESTS DATE_____

Height_____ Weight_____ Small Pox_____
Result____
Eyes_____ Vision_____ Tuberculin Test (Required)_
Ears_____ Nose_____ Result_____
Teeth: Temporary_____ Chest X-ray_____Result_____
Permanent_____ DPT_____Booster_____
Tonsils_____ Polio Vaccine: Sabin_____Number_____
Nutrition_____ Salk_____Number_____
Latest Booster - Type_____Number_____
Measles Vaccine_____ Mumps Vaccine_____
German Measles Vaccine_____

Glands (specify)

_____

_____

Heart

_____

_____

Lungs

_____

_____

_____

Orthopedic

Skin

Hernia

FAMILY PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION
(continued)

Nervous System (specify if epilepsy)

_____
_____
_____
_____

Speech

_____
_____
_____
_____

Remarks or Special Instructions:

_____
_____
_____
_____

Previous Diseases/Operations:

_____
_____
_____
_____

Is this child capable of carrying a full program of school work including gymnastics and athletics? Yes_____ No_____

Must the school program be modified to meet the needs of this child? Yes_____ No_____

By restriction of use of stairs? Yes_____ No_____
By special seating accommodations? Yes_____ No_____
Other (specify)_____ Yes_____ No_____
_____

Examining Physician_____
_____

Signature

_____ _____
_____

Date Please Print Name

Adopted: August 1, 2002