

LONDONDERRY SCHOOL DISTRICT  
 Londonderry, New Hampshire 03053

**PHYSICAL EXAMINATION**

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 PARENT/GUARDIAN \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
 NAME OF EXAMINING PHYSICIAN \_\_\_\_\_ TELEPHONE # \_\_\_\_\_  
 PHYSICIAN'S ADDRESS \_\_\_\_\_ FAX # \_\_\_\_\_

DATE OF EXAM \_\_\_\_\_ AGE \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_ PULSE \_\_\_\_\_ B/P \_\_\_\_\_

Allergies (specify): _____ _____ Asthma/Wheezing Chicken Pox Diabetes Ear Infection	<u>PREVIOUS HEALTH HISTORY</u> Headaches/Migraines Heart Condition Seizure Disorder Skin Disorder Sinus Condition Serious Injury _____ _____	Fractures _____ Other Medical Condition _____ _____ Surgery (list and date) _____ _____
	_____ _____	_____ _____

<u>GENERAL APPEARANCE</u>	ABDOMEN
<u>SKIN</u>	<u>GENITALIA</u> Undescended Testicle Hernia
<u>THROAT/GLANDS</u>	<u>MUSCULOSKELETAL</u> Scoliosis Extremities
<u>EYES/EARS</u>	HEART Murmur/Rhythm
<u>LUNGS</u>	<u>OTHER OBSERVATIONS</u>
<u>MEDICAL CONCERNS</u>	<u>MEDICATIONS</u>

RECOMMENDATIONS FOR SPORTS AND/OR PHYSICAL EDUCATION ACTIVITIES:

( ) Full Participation Approved ( ) Limited (Explain):

IMMUNIZATION	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
DPT	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____
POLIO	_____	_____	_____	_____	_____
DT or Td	_____	_____	_____	_____	_____
MEASLES	_____	_____	_____	_____	_____
MUMPS	_____	_____	_____	_____	_____
TB TEST	_____	_____	_____	_____	_____
HEP B	_____	_____	_____	_____	_____
VARICELLA	_____	_____	_____	_____	_____
OTHER	_____	_____	_____	_____	_____

WHAT IMMUNIZATIONS WERE GIVEN TODAY? \_\_\_\_\_

PLEASE INDICATE APPOINTMENT DATES FOR INCOMPLETE IMMUNIZATIONS: \_\_\_\_\_

DATE EXAMINED \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_