ישיבה קטנה דפילאדעלפיא

YESHIVA KETANA
OF PHILADELPHIA

5900 Drexel Rd., Philadelphia, PA 19004♦ Phone: 610-756-8367♦ www.ykphilly.org

Entrance to Yeshiva

REPORT OF PHYSICAL EXAMINATION

Name ______________________________________ Birthdate ___________ Grade___________
Last *First*

Home Address ____ Home Phone_______________
Street *City* *Zip*

Vaccine	Doses				Please list exact dates					
DtaP DPT Td	**1**		**2**		**3**		**4**		**5**	
	6		**7**							
Tdap* (Adacel)	**1**		**2**							
Polio (OPV, IPV)	**1**		**2**		**3**		**4**		**5**	
Hepatitis B	**1**		**2**		**3**					
MMR	**1**		**2**							
Varivax	**1**		**2**		**Varicella Disease Date:**					
Meningococcal*MCV									**Other**	
PPD			**MM results:**		**INH Therapy**				**Other**	

Allergy: ____ Epi-pen ____Yes ____No

Medical History: ____

____

Surgical History: ____

____

Examination Date:__________________

Height ____ (inches) Weight ____ (lbs) BMI *for Age Percentile* _____ BP____/____Pulse____

	Normal	Abnormal		Normal	Abnormal
General Nutrition ______________	☐	☐	**Neuro Muscular** ______________	☐	☐
Skin ________________________	☐	☐	**Skeletal** ____________________	☐	☐
Ears ________________________	☐	☐	**Emotional Status**______________	☐	☐
Nose & Throat ________________	☐	☐	**Hearing** ____________________	☐	☐
Glands ______________________	☐	☐	**Scoliosis (Binding Pos)** _________	☐	☐
Heart _______________________	☐	☐	**Speech** _____________________	☐	☐
Lungs _______________________	☐	☐	**Abdomen** ____________________	☐	☐
Vision R: 20/_____ L: 20/_____			**Wears Corrective Lens Yes / No**		

Is this student currently under treatment? No _____ Yes ______________________________

Please list any current or long-term medications (reason for administration):_______________

____

Should this student have any physical restrictions? _________________________________

Signature of Examining Physician __________________ Phone ____________________

Printed Name ______________________ Office Stamp ____________________________