ישיבה קטנה דפילאדעלפיא

YESHIVA KETANA

OF PHILADELPHIA

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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
General Nutrition ____________	☐	☐
Skin ____________	☐	☐
Ears ____________	☐	☐
Nose & Throat ____________	☐	☐
Glands ____________	☐	☐
Heart ____________	☐	☐
Lungs ____________	☐	☐

Vision R: 20/______ L: 20/______

	Normal	Abnormal
Neuro Muscular ____________	☐	☐
Skeletal ____________	☐	☐
Emotional Status____________	☐	☐
Hearing ____________	☐	☐
Scoliosis (Binding Pos) ____________	☐	☐
Speech ____________	☐	☐
Abdomen ____________	☐	☐

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** ____________________