THE INDEPENDENCE SCHOOL PHYSICAL EXAM

Name _____ Gender_____ Date of Birth _____

PART I – COMPREHENSIVE EXAM

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION	Check (√) NORMAL	ABNORMAL	REFERRAL	HEALTHCARE PROVIDER COMMENT
General Appearance				
Skin				
Eyes				
Ears				
Nose/Throat				
Mouth/Dental				
Cardiovascular				
Respiratory				
Thyroid				
Gastrointestinal				
Genito-Urinary				
Neurological				
Musculoskeletal				
Spinal Examination				
Nutritional Status				
Mental Health Status				

FOR CHRONIC & LIFE THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency care plan for school.

Please attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals: _____

_____

_____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	NO

Print Name: _____ Signature: _____ Date: _____

☐ Physician (MD or DO) ☐ Clinical Nurse Specialist (APN) ☐ Advanced Practice Nurse (APN) ☐ Physician Assistant (PA)

Address: _____ Phone: _____

CHILD'S NAME _____

PART II-IMMUNIZATIONS

Entire section below to be completed by MO/DO/APN/NP/PA
Printed VAR form may be attached in lieu of completion

DTaP/DT / /	DTaP/DT / /	DTaP/DT / /	DTaP/DT / /	DTaP/DT / /
OPV/IPV / /	OPV/IPV / /	OPV/IPV / /	OPV/IPV / /	OPV/IPV / /
PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /
Hib / /	Hib / /	Hib / /	Hib / /	
MMR / /	MMR / /	HepB/HepB-2 / /	HepB/HepB-2 / /	HepB / /
VAR / /	VAR / /	RV-2/RV-3 / /	RV-2/RV-3 / /	RV-3 / /
MCV4 / /	MCV4 / /	HPV / /	HPV / /	HPV / /
Hep A / /	Hep A / /	Td/Tdap / /	Td/Tdap / /	Td / /
Influenza / /	Influenza / /	PPSV23 / /	PPSV23 / /	
Other: / /	Other: / /	Other: / /	Other: / /	Other: / /

Child fully immunized per DPH/CDC recommendations ☐ Yes ☐ No

PART III- SCREENING & TESTING

Entire section below to be completed by MO/DO/APN/NP/PA

Screen	Height: _____ (inches) Weight: _____ (pounds) BMI:_____ BMI Percentile: _____ BP: _____ Pulse:_____ Other:_____
Dental Screen	____ **Problem Identified:** Referred for treatment ____ **No problem:** Referred for prevention ____ **No Referral:** Already receiving dental care
Tuberculosis Screen	All new enters must have a TB test or TB Risk Assessment, which must be done within 12 months prior to school entry. Risk Assessment: Date _____ Results: ☐ Test Required ☐ Test Not Required Mantoux Skin Test: Date: _____ Results: _____MM Other: (type) _____ Date: _____ Results: _____MM
Lead Test	Blood lead test required for children age 6 months through 6 years Date: _____ Results: _____
Other Screen	Hearing: Type: _____ Date: _____ Results: _____ Referral: ☐ No ☐ Yes ____ Date Vision: Type: _____ Date: _____ Results: _____ Referral: ☐ No ☐ Yes ____ Date Other: Type: _____ Date: _____ Results: _____ Referral: ☐ No ☐ Yes ____ Date