EAST QUOGUE SCHOOL
PRIVATE PHYSICIAN'S EXAMINATION

Name	Date of Birth
Address	Height Weight

PHYSICAL EXAMINATION

Nose	Ears	Eyes	Teeth
Tonsils	Glands	Throat	Lungs
Heart	Hernia	Nervous System	
Operations	Posture	Orthopedic	
Speech	Nutrition	Allergy	

Serious Injury _____

Other _____

Comments _____

(If more room is needed, please use back of form)

IMMUNIZATION RECORD

	Date	Date	Date	Date	Date
Polio (TOPV or IPV)					
Measles					
Varivax (Chickenpox)					
Diphtheria (DTP/DT/TD)					
Tetanus Toxoid					
M/M/R					
HIB					
Hep B					

Is this child taking any medication on a regular basis?_____

_____

Is this child able to participate in Physical Education?_____

_____

If not, what restrictions: _____

_____

_____ _____

Date of Examination Physician's Signature