

Immunization Record & Physical Report

Child Name: _____

Male Female Date of birth: _____ Grade: _____

Date of physical: _____

Measurements & Testing

Height _____ Percentile _____

Weight _____ Percentile _____

Blood Pressure _____

Urinalysis _____

Vision & Hearing

Hearing AD _____ Uncorr. OD _____

Hearing AS _____ Uncorr. OS _____

Hct/Hgb _____ Corr. OD _____

Color _____ Corr. OS _____

Overall: Please indicate by a check any positive findings on physical examination or any handicapping disability and describe fully any limitations below:

Eyes _____ Ears _____ Nose _____

Throat _____ Teeth _____ Lymph _____

Thyroid _____ Heart _____ Lungs _____

Abdomen _____ Hernia _____ Genit. _____

Femoral _____ Muscle _____ Skin _____

Nutrition _____ Speech _____ Nervous _____

Allergies _____ Specl Diet _____ Meds _____

Description(s):

Immunizations & Diseases

DTaP TOPV TINE Td MMR Other _____ Other _____

(Please attach a list of immunizations, dates, etc.)

Check the appropriate line relating to the physical status of the child:

Full physical activity in school

Modified physical activity because of _____

Full participation in contact sports

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Address: _____

immunizationrecord.doc created by Erin Cunia 22-Dec-09, revised 23-Dec-09