IMMACULATE CONCEP†ION REGIONAL SCHOOL

1321 East Division, Mount Vernon, WA 98274, (360)428-3912, Fax (360)424-8838

PHYSICAL EXAMINATION

Name_____ Physician_____ Date _____

Address_____ Phone #_____ Age _____ Grade _____

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Height_____Weight_____

BP_____

Vision: Glasses/Contacts_____

Lt:_____ Rt:_____

General Appearance_____

Face and Skin_____

Lymph Nodes _____

Eyes _____

Ears _____

Nose _____

Neck _____

Thorax _____

Heart _____

Lungs _____

Back _____

Abdomen_____

Genitalia _____

Neurological _____

Extremities _____

Health History (to be filled out by parent)

Immunizations Current: yes ____ no ____

Medications:_____

Medicine Allergies:_____

Hospitalizations:_____

Major Illnesses:_____

Current Problems:_____

Past Injuries:_____

Significant Family History:_____

Other Concerns:_____

_____

Parent Signature:_____

Date:_____

Physician's Signature _____ Physician's Phone # _____

Recommendations/Remarks _____

_____

_____

Limitations_____

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