The Timothy School
Physical Exam Form (Doctor Signature Required)

Required for ALL students annually

Student's Name: _____ **Date of Exam:** _____

Date of Birth: _____ **Gender:** Male ☐ Female ☐

Age at time of exam: _____ **Upcoming School Year Grade:** _____

Medical History Information	
Allergies ☐ Medicines ☐ Pollens ☐ Food ☐ Insects	**List specific allergy & reaction:**
Significant Past Medical History	
Current Medications	

I hereby certify that to the best of my knowledge all of the information is true and complete. I give consent for an exchange of health information between the school nurse and health care providers.

Parent(s)/Guardian Signature _____ **Date of Signature** _____

Physcial Exam					
		Check one			*Abnormal Findings/Recommendations/Referrals
		Normal	*Abnormal	Defer	
Height	inches				
Weight	pounds				
BMI					
BMI-for Age Percentile	%				
Pulse					
Blood Pressure	/				
Hair/Scalp					
Skin					
Eyes/Vision	Corrected ☐				
Ears/Hearing					
Nose and Throat					
Teeth and Gingiva					
Lymph Glands					
Abdomen					
Genitourinary					
Neuromuscular System					
Extremities					
Spine (Scoliosis)					
Other					

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Health Care Providers: Please photocopy immunization history from student's record –OR- insert information below.

Vaccine	Document: Date (month/day/year) for each immunization				
Diphtheria, Pertussis, Tetanus DTap, DTP, DT, Td					
Tdap					
Polio Type: OPV ☐ or IPV ☐					
Hepatitis B (indicate if 2 dose series)					
Measles- Mumps- Rubella (MMR)					
Meningococcal (MCV)					
HPV					
Varicella (Chicken Pox) Vaccine ☐ Disease ☐					
Other Vaccines (type and date)					

Immunization Exemption(s)			
Medical ☐	Date Issued:	Reason:	Date Rescinded:
Medical ☐	Date Issued:	Reason:	Date Rescinded:
Medical ☐	Date Issued:	Reason:	Date Rescinded:

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

Tuberculin Test			
Date Applied:		**Date Read:**	

Medical Conditions which require medication, restriction or activity, or which may affect education

Parent/Guardian was present during exam:	Yes ☐	No ☐

Physicians Name _____ **Physicians Phone Number** _____

Physicians Signature _____ **Date of Signature** _____