

# TRINITY LUTHERAN SCHOOL

# ANNUAL PHYSICAL 2015-2016

40 W. Nicholai Street  
Hicksville, NY 11801

516 931-2211 fax 516 931-6345

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Emergency phone numbers: Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

## IMMUNIZATION RECORD

Immunization Record Attached \_\_\_\_\_

MMR \_\_\_\_\_

POLIO \_\_\_\_\_

DPT \_\_\_\_\_

Tdap \_\_\_\_\_

Hep B \_\_\_\_\_

HIB \_\_\_\_\_

Varicella \_\_\_\_\_ Varicella Disease Date: \_\_\_\_\_

Other \_\_\_\_\_

## PHYSICAL EXAMINATION

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BODY MASS INDEX \_\_\_\_\_ BMI PERCENTILE \_\_\_\_\_

PULSE RATE \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ SCOLIOSIS \_\_\_\_\_

Eyes: \_\_\_\_\_ Abdomen: \_\_\_\_\_ Exam Completely Normal \_\_\_\_\_

Ears: \_\_\_\_\_ Hernia: \_\_\_\_\_

Nose & Throat: \_\_\_\_\_ Heart: \_\_\_\_\_

Mouth & Teeth: \_\_\_\_\_ Lungs: \_\_\_\_\_

Skin: \_\_\_\_\_ Orthopedic: \_\_\_\_\_

HEARING \_\_\_\_\_ VISION R \_\_\_\_\_ L \_\_\_\_\_ with/ without glasses/contact lenses

ALLERGY \_\_\_\_\_ Epipen required: Yes / No

ASTHMA YES / NO      DIABETES YES / NO

MEDICATION REQUIRED FOR SCHOOL YES / No \_\_\_\_\_ if yes please specify \_\_\_\_\_

KNOWN OR SUSPECTED DISABILITY \_\_\_\_\_

SPECIFY MEDICAL ACCOMODATIONS NEEDED FOR SCHOOL \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

***Free from contagions & physically qualified for all physical education, sports, camp, playground & school activities without restrictions: Yes / No***

PROVIDER'S SIGNATURE: \_\_\_\_\_

Provider's Stamp Below:

Actual Date of Examination: \_\_\_\_\_