# RSU 40 PHYSICAL EXAMINATION FORM

Student Name: _____ Date of Birth: _____ Grade: _____

Address: _____ School: _____

Parent's Name: _____

## PHYSICAL EXAMINATION SHALL INCLUDE THE FOLLOWING:

Urinalysis: _____ Skin: _____ Scalp: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____

Teeth and oral hygiene: _____

Neck (thyroid, lymph nodes): _____

Blood Pressure: Systolic: _____ Diastolic: _____ Pulse: _____

Nutrition: _____ Abdomen: _____

Hernia: _____ Lungs: _____ TB Test: Positive: _____
Negative: _____

Genitalia (Males): _____ If positive, Chest X-Ray: _____

Menstruation (Female): _____ Any history of: Allergy: _____
Seizures: _____

Height: _____ Weight: _____ Convulsions: _____

Lead Test Results: _____

Posture:_____ Bones & Joints: _____

Remarks: _____

## IMMUNIZATIONS: (Please give all dates – month, day and year)

| DPT/DTaP | OPV/IPV | MMR | VARICELLA | Hep A |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | | | |
| _____ | _____ | HIB | HEP B | Meningococcal |
| _____ | | _____ | _____ | _____ |
| | Tdap | _____ | _____ | |
| | _____ | _____ | _____ | OTHER |
| | | _____ | | _____ |

***PLEASE RETURN THIS FORM TO:***
**RSU 40 SCHOOL HEALTH SERVICES**
**PO Box 701**
**1070 Heald Highway**
**Union, Maine 04862**
**Or Fax To: 207-785-3124**

Signed: _____
(Physician)

Date: _____