

# Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Allergies \_\_\_\_\_

**Current Medications: (List name, dosage, and time)**

1. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_  
2. \_\_\_\_\_ Dosage \_\_\_\_\_ Time \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_

Eyes: \_\_\_\_\_

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

**Lead Level** (if indicated): \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

**Sickle Cell** (If indicated): \_\_\_\_\_

Chest: \_\_\_\_\_

Heart: \_\_\_\_\_

**P.P.D.: (Recommended)**

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

Date Given: \_\_\_\_\_

Extremities: \_\_\_\_\_

Date Read: \_\_\_\_\_

Posture/Scoliosis: \_\_\_\_\_

Results: \_\_\_\_\_

- Physically fit to participate in all physical education programs? Yes No  
If "No" please explain: \_\_\_\_\_
- Please list any condition that should be considered in planning this child's school day: \_\_\_\_\_

**Immunization Record: (Month/Day/Year)**

DtaP/Tdap:

Hepatitis B:

Hepatitis A:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

1. \_\_\_\_\_  
2. \_\_\_\_\_  
**Pertussis:**  
1. \_\_\_\_\_

IPV (please indicate if OPV)

**M.M.R.:**

**Menactra:**

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

1. \_\_\_\_\_  
2. \_\_\_\_\_

1. \_\_\_\_\_  
**HPV:**  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

**Varicella:**

1. \_\_\_\_\_  
2. \_\_\_\_\_

Physician Completing this form: \_\_\_\_\_

Please Print/Stamp

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_