

## PHYSICAL EXAMINATION

Students Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 (print)

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. BMI \_\_\_\_\_  
 Vision: Right 20/ \_\_\_\_\_ Corrected 20/ \_\_\_\_\_ Urinalysis date \_\_\_\_\_  
 Left 20/ \_\_\_\_\_ Corrected 20/ \_\_\_\_\_ Sugar \_\_\_\_\_ Albumin \_\_\_\_\_

√= Normal      √= Abnormal      comment

1. Head, Ears, Nose, or Throat		
2. Eyes (with Ophthalmoscope)		
3. Hearing		
4. Neck-Thyroid		
5. Respiratory		
6. Cardiovascular		
7. Gastrointestinal		
8. Hernia		
9. Genitourinary		
10. Metabolic/ Endocrine		
11. Neuropsychiatric		
12. Skin		
13. Menstrual		



	Yes	No
14. To the best of your knowledge is this person free from physical or mental impairment including alcohol or drug dependency?		
15. Are there any restrictions of physical activity (athletics, gym, etc.)		
16. Is this patient now under treatment for any medical or emotional condition?(comment below)		
17. Is the patient on long-term medication? (if yes specify)		

### IMMUNIZATIONS:

The State of New York requires that no child shall be admitted to school without appropriate certification of immunization against diphtheria, poliomyelitis, measles, mumps, rubella and hepatitis B or has shown acceptable evidence of excuse for medical or religious reasons. Specifically, this means that the child has received:

- 3 or more doses of diphtheria toxoids (usually administered as either DTP or TD).
- Either 3 or more doses trivalent oral poliovirus vaccine (TOPV) or enhanced inactivated poliovirus (EIPV), or 4 doses inactivated poliovirus (IPV).
- 2 doses live measles vaccine administered on or after first birthday, or history of physician-diagnosed measles disease, or evidence of immunity.
- Either 1 dose of live mumps vaccine administered on or after first birthday, or a history of physician-diagnosed mumps disease, or serologic evidence of immunity.
- Either 1 dose of live rubella vaccine administered on or after first birthday, or serologic evidence of immunity.
- 2 doses of MMR may be given in place of measles, mumps and rubella.
- 3 doses of Hepatitis B for 7<sup>th</sup> and 8<sup>th</sup> graders.
- **Varicella immunization**

**Immunization Record-** Fill in all vaccines received –month and year

DPT			
HIB			
OPV			
IPV			
Td			
MMR			
Measles			
Mumps			
Rubella			
Hepatitis B			
Meningococcal			
Varicella			

**PPD Mantoux Test** (required within one year prior to first year at School)

Date \_\_\_\_\_ Results \_\_\_\_\_ mm

If test is positive, chest x-ray is required, attach report, results and treatment

**Signed** \_\_\_\_\_  
 (Examining Practitioner)

**Date of examination** \_\_\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone # ( ) \_\_\_\_\_ fax # \_\_\_\_\_

WHEN COMPLETED, MAIL DIRECTLY TO: THE STONY BROOK SCHOOL, 1 CHAPMAN PARKWAY, STONY BROOK, N.Y. 11790