WINDHAM SCHOOL DISTRICT
OFFICE OF THE SCHOOL NURSE
WINDHAM CENTER SCHOOL
PHYSICAL EXAMINATION

Phone (603) 432-7312 Fax (603) 432-1189

To be filled out by your DOCTOR

NAME OF CHILD____DATE OF BIRTH_____________

DATE OF PHYSICAL EXAMINATION____

Vision Screening___________________________________ Heart______________________________
Hearing Screening__________________________________ Lungs______________________________
Nose & Throat_____________________________________ Abdomen____________________________
Glands____ Urine______________________________
Teeth____ Blood______________________________
Blood Pressure_____________________________________ Hernia_____________________________
Height____ Weight_____________________________
Skin____Orthopedic __________________________

HISTORY OF COMMUNICABLE DISEASES: PLEASE LIST YEAR
Measles_______________Chicken Pox__________________Rubella_______________Scarlet Fever___________
Mumps_______________Diphtheria____________________Other_______________________________________
Does this child have any allergies? ____

IMMUNIZATIONS: PLEASE LIST DAY / MONTH/ YEAR

VACCINE	DATE GIVEN	VACCINE	DATE GIVEN
DPT 1	_______________	OPV/IPV 1	_______________
DPT 2	_______________	OPV/IPV 2	_______________
DPT 3	_______________	OPV/IPV 3	_______________
DPT/DTaP 4	_______________	OPV/IPV 4	_______________
DPT/DTaP 5	_______________	MMR 1	_______________
Hib 1	_______________	MMR 2	_______________
Hib 2	_______________	Varicella	_______________
Hib 3	_______________	HEP B 1	_______________
Hib 4	_______________	HEP B 2	_______________
Lead/EP dates	_______________	HEP B 3	_______________
TB test	_______________		
Varivax	#1_____________		
Varivax	#2______________		
Other	_______________		

This child is physically capable of carrying a full school program and may participate in physical education:

YES_______________NO_____________________

Exceptions:____

<u>Does this child require an EpiPen for allergic reactions</u> YES________________ NO_______________

Is this child on daily medication at home or school. YES_________________ NO_________________

If yes, please list medication and reason for taking____

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PHYSICIAN'S SIGNATURE______________________________________**DATE**________________

PHYSICIAN'S STAMP____________________________________**Telephone #**__________________