AO-13
Revised 1/09

METROPOLITAN SCHOOL DISTRICT OF MT. VERNON
PHYSICAL EXAMINATION RECORD

The school requests that this form be completed by the family physician.

____________________ (Name of Student) ________ (Sex) ____________________ (Birthdate)

____________________ (Parent or Guardian) ____________________ (Address) ____________________ (Phone)

1. Height ____________________
   Weight ____________________
2. Vision (Snellen) Right ________________
   Left ________________
   Glasses Right ________________
   Left ________________
3. Blood Pressure ________________
4. Urinalysis ________________
5. Teeth ________ Caries ________________
6. Ears - Right ________________
   Left ________________
7. Nose ________________
8. Throat ________________
9. Tonsils ________________
10. Lymph Nodes ________________
11. Thyroid ________________
12. Heart ________________
13. Lungs ________________
14. Abdomen ________________
15. Hernia ________________
16. Orthopedic Impairments ________________
17. Posture ________________
18. Nutrition ________________
19. Skin ________________
20. General Condition
21. Epilepsy – Yes ________________
    No ________________
22. Has child been tested for:
    (a) Sickle cell anemia ________________
    (b) Lead poisoning ________________
23. Allergies ________________
    ____

Does the child show any signs or symptoms of scoliosis? Yes ________ No ________
If so, please explain: ________________________________

DEP/DT					
POLIO					
M-M-R					
HIB					
HEP B					
VARIVAX					
PNEUMONIA					
MENINGITIS					
GARDASIL					
HEP A					

Is this child physically fit to participate in physical activities? Yes ________ No ________
Does this child have any physical restrictions or handicaps? If so, please explain. ________________

____

____________________ (Date) ____________________ (Physician's Signature)