CENTRALIA R-VI SCHOOL DISTRICT
CENTRALIA, MO
PHYSICAL EXAM FORM – TO BE COMPLETED BY PHYSICIAN
PHONE (573) 682-2014 or 682- 3561 FAX (573) 682-1369

Name _____ Grade _____ Date of Birth _____
Address _____ Age _____ Male/Female
Height _____ Weight _____ B/P _____ Pulse _____
Medicine taken regularly:_____
Conditions which could affect school activities:_____
Nutrition _____ Mouth/Teeth _____ Speech _____
Posture _____ Reflexes_____
Eyes/Ears_____
Vision OD_____ OS_____ OU_____ Nose/Throat_____ _____
Heart _____ Lungs_____
Abdomen_____
Skin_____ Any physical restrictions_____

Please check if your child has had the following illness:
Allergies ___ if yes, to medication_____ to food_____
other_____
Asthma ___ if yes, current medication_____
Chicken Pox____
Diabetes____ if yes, current treatment plan_____
Ear Infections/Tubes_____
Pneumonia ____
Epilepsy/Seizures____ if yes, current medication_____
Surgeries_____
Other medical history_____
_____

Immunization History Dates:
DTP, DTap _____, _____, _____, _____, _____ MMR _____, _____
OPV/IPV _____, _____ , _____, _____ Varicella _____, _____
Hep B _____, _____, _____, _____ Hep A _____, _____
Hib _____, _____, _____, _____ Tdap booster _____ (8th grade)
TB test _____, _____ Other
_____

Physician Signature_____

Physician's Name_____ Date_____
Address_____ Phone_____
Fax _____