

Mt. Blue Campus

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PHYSICIAN'S EXAMINATION (to be filled out by student's physician)

Name		M/I	F Bi	rthdate	
Grade Sch	001				
Height	Weight	BP	P	BMI _	
Visual acuity R	WeightL	Hea	ring R	db L	db
yes no		yes	<u>no</u>		
	t headaches			ng problem	
dizzine	dizziness/fainting		behavior/emotional problem		
seizure	seizures		physic	cal limitation	
	problem		scolio		
hearing problem			heart disease		
asthma/chronic cough			chronic illness		
allergy			learning problem		
frequent abdominal pain			special diet needs		
diabete	S		dental	problems	
PROBLEM LIST		PLAN (meds, services, follow-ups)			
•					
		-			
3		-			
	NS: (BOLD immuni NTH/DAY/YEAR an OPV /IPV)	V
				Pneumoc	
		Other			
TD/dT	· · · · · · · · · · · · · · · · · · ·	-	 -		
	VARICELLA:			disease date	
	OI	titer results and	date drawn		
Student may partic		orogram includi	ig a vigorous	physical education	on program
	ipate in a full school p		ig a vigorous j	physical education	on program
			ig a vigorous j	physical education	on program
	ipate in a full school p		ng a vigorous j	physical education	on program
	ipate in a full school petics. (Specify limits		ng a vigorous j		on program