Wawasee Community Schools
Immunization Records and Physical Examination

Name _____ Sex _____ Birthdate _____
First Middle Last

School _____ Grade _____

PHYSICAL EXAM: To be filled out by your doctor ✓= Normal

Weight _____ Vision _____ Glasses ☐
Height _____ Hearing R _____ L _____
BP _____
Hct/Hgb (Optional) _____
Urinalysis _____

Eyes _____ Glands/Lymph _____
Ears _____ Abdomen _____
Nose _____ Hernia _____
Throat _____ Reflexes _____
Heart _____ Genitalia _____
Lungs _____ Orthopedic _____

Explain any physical activity restrictions. _____

Does your child take a medication regularly? ☐ Yes ☐ No Explain _____

Comments _____

Dental exam in the last 6 months? ☐ Yes ☐ No

IMMUNIZATION RECORDS:

	1 M/D/Y	2 M/D/Y	3 M/D/Y	4 M/D/Y	5 M/D/Y	6 M/D/Y
DTaP						
Td						
OPV/IPV (Specify)						
Hib						
Hep B						
MMR						
Measles						
Rubella						
Mumps						
Varicella						
Hepatitis A						

Physician's Signature **Date**

Office Name Office Phone Number