# TRINITY LUTHERAN SCHOOL

## ANNUAL PHYSICAL 2017-18

**40 W. Nicholai Street**
**Hicksville, NY 11801 516 931-2211 fax 516 931-6345**

**Name**_____________________________________________Date of Birth ____________ Grade ___________

Address_________________________________________________________________Phone _____________

Emergency phone numbers: Mother ___________________Father __________________ Other _____________

**IMMUNIZATION RECORD**

**Immunization Record Attached ________**

**MMR** ______________ ______________

**POLIO** ______________ ______________ ______________ _______________

**DPT** ______________ ______________ ______________ _______________ ______________

**Tdap** ______________ _______________

**Hep B** ______________ _______________ _______________

**HIB** ______________ _______________ _______________

**Varicella** _____________ _______________ **Varicella Disease Date:** _________________

**Other** _______________ _______________ _______________

**PHYSICAL EXAMINATION**

**HEIGHT**___________ **WEIGHT**____________**BODY MASS INDEX** ____________ **BMI PERCENTILE**_______

**PULSE RATE** ___________ **BLOOD PRESSURE**________________ **SCOLIOSIS** _____________________

Eyes: _____________________
Ears: _____________________
Nose & Throat:______________
Mouth & Teeth: ____________
Skin: ______________________

Abdomen:_____________________
Hernia:_______________________
Heart: ________________________
Lungs: ________________________
Orthopedic: ____________________

Exam Completely Normal_________

**HEARING** ___________________ **VISION R**___________ **L** _____________ with/ without glasses/contact lenses

**ALLERGY** ________________________________________________________________ **Epipen required: Yes / No**

**ASTHMA YES / NO DIABETES YES / NO**

MEDICATION REQUIRED FOR SCHOOL YES / No _____ *if yes please specify* ______________________________________________

KNOWN OR SUSPECTED DISABILITY ___________________________________________________________________________

SPECIFY MEDICAL ACCOMODATIONS NEEDED FOR SCHOOL _______________________________________________________

Activity Restrictions _________________________________________________________________________

***Free from contagions & physically qualified for all physical education, sports, camp, playground & school activities without restrictions: Yes / No***

**PROVIDER'S SIGNATURE:** ______________________________________________________ Provider's Stamp Below:

**Actual Date of Examination:** ______________________________

This exam complies with the NYSED requirements and is valid for twelve months . Rev.4/08