

**MORIAH CENTRAL SCHOOL DISTRICT**  
**PHYSICAL EXAMINATION FORM**  
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**Education Law requires a physical examination of a student prior to entrance into a new school district AND for Grades 1, 3, 7, and 10 AND for Sports Participation.** Please have your physician complete this report prior to registration. For your convenience, the completed form may be faxed to the school registrar at (518) 546-7895.

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

**Height** (inches) \_\_\_\_\_ **Weight** \_\_\_\_\_ **BMI** \_\_\_\_\_ **BP** \_\_\_\_\_ **Pulse** \_\_\_\_\_

Eyes \_\_\_\_\_ **Vision** (with/without glasses) (R) \_\_\_\_\_ (L) \_\_\_\_\_

Ears (Otosopic) \_\_\_\_\_ Genito-Urinary \_\_\_\_\_

Lymph Nodes \_\_\_\_\_ Musculo-Skeletal \_\_\_\_\_

Thyroid \_\_\_\_\_ Scoliosis (Negative) \_\_\_\_\_ (Positive) \_\_\_\_\_

Nose \_\_\_\_\_ Feet \_\_\_\_\_

Tonsils \_\_\_\_\_ Skin (Non-Commun) \_\_\_\_\_

Teeth \_\_\_\_\_ Abdomen \_\_\_\_\_

Heart \_\_\_\_\_ Nervous System \_\_\_\_\_

Lungs \_\_\_\_\_ Speech \_\_\_\_\_

Hernia \_\_\_\_\_ Nutrition \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

**Immunization Record:**

**Polio** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **HepB#1** \_\_\_\_\_ **HepB#2** \_\_\_\_\_

**HepB#3** \_\_\_\_\_

**DPT (Tdap)**  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **MMR#1** \_\_\_\_\_ **MMR#2** \_\_\_\_\_

**Hib** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Influenza** \_\_\_\_\_

**Varicella Series#1** \_\_\_\_\_ **#2** \_\_\_\_\_ **Disease** \_\_\_\_\_ **PPD** \_\_\_\_\_ **Result** \_\_\_\_\_ mm

**Induration**

**Meningococcal** \_\_\_\_\_ **HPV#1** \_\_\_\_\_ **HPV#2** \_\_\_\_\_

\_\_\_\_\_  
**Health Care Provider (Signature)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Phone Number**

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**Address**

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