DERRY COOPERATIVE SCHOOL DISTRICT

N.H. School Administrative Unit #10

SCHOOL HEALTH PHYSICAL EXAMINATION

Name of Student: _____ DOB: _____
Height: _____ Weight: _____ Urine: _____ HGB.HCT: _____ Lead Level: _____ BP: _____

Hearing & Vision Screening:

_____

Skin/Scalp:

_____

Nose/Mouth/Throat:

_____

Neurological/Muscular:

_____

Spine & Extremities:

_____

Glands, Including Thyroid:

_____

Chest/Breast:

_____

Heart/Lung:

_____

Abdomen:

_____

Genitalia:

_____

Allergies (Asthma, etc.):

_____

Recommendations:

_____

CHILD IS PHYSICALLY CAPABLE OF FULL ACADEMIC & PHYSICAL EDUCATION PROGRAM: ____ YES ___ NO

EXCEPTIONS:

_____

ARE ALL IMMUNIZATIONS UP TO DATE ACCORDING TO NH REGULATIONS: _____ YES _____ NO

PLEASE ATTACH DOCUMENTATION OF ALL IMMUNIZATIONS

Date of Examination: _____ Physicians Signature: _____

Print Physician's Name: _____

Address/Telephone #: _____

PHYSICAL EXAMINATION COMPLETED WITHIN ONE YEAR PRIOR TO ENTERING PUBLIC SCHOOL
TRANSFER STUDENTS WILL NEED PHYSICAL IF ONE IS NOT IN RECORDS

UPDATED 03/09