NOTE: Return this form to the **Guidance Office** after exam has been completed

******** **This is not interchangeable with the WIAA Card physical.** ********

PUPIL HEALTH EXAMINATION
WATERFORD HIGH SCHOOL

Last Name ______ First Name ______ Middle Name ______ Grade ______

Address ______ City ______ Zip Code ______

Birthdate ______ Parent or Guardian ______ Family Doctor ______

PAST HISTORY:
______
______
______

Glasses: ______

Orthopedic: ______

Other: ______
______

Date of this examination: ______

Height: ______

Weight: ______

SUMMARY OF ABNORMAL FINDINGS:

______

IMMUNIZATIONS:

D.P.T. (Must have four) ______ Mo/Day/YR ______ Mo/Day/YR
______ Mo/Day/YR ______ Mo/Day/YR
______ Mo/Day/YR ______ Mo/Day/YR

Adolescent Booster (Tdap) ______ Mo/Day/YR

Polio: (Must have four) ______ Mo/Day/YR ______ Mo/Day/YR
______ Mo/Day/YR ______ Mo/Day/YR
______ Mo/Day/YR ______ Mo/Day/YR

1st MMR (Must have after 1st Birthday)
2nd MMR ______ 1st- Mo/Day/YR ______ 2nd- Mo/Day/YR

Hepatitis B ______ Mo/Day/YR ______ Mo/Day/YR ______ Mo/Day/YR

Varicella (Chickenpox Disease) Mo ______ YR ______

Varicella Vaccine (Chickenpox) ______ Mo/Day/YR ______ Mo/Day/YR
(2 doses)

Meningo – not required ______ Mo/Day/YR

Hepatitis A - not required ______ Mo/Day/YR ______ Mo/Day/YR

______

CLASSIFICATION FOR PHYSICAL ACTIVITY (Specify)

Unlimited activity ______

Limited activity ______

Describe: ______
______

Full program of school work ______
Modified program ______
Homebound Instruction ______
Special School Placement:
Orthopedic school ______
Hard of hearing ______
Other ______

RECOMMENDATIONS FOR FOLLOW UP BY SCHOOL NURSE:

______

Physician Signature ______

Rev 12-12