TRI-VILLAGE LOCAL SCHOOLS
PHYSICAL FORM

DENTIST'S REPORT

The following services have been performed:

Please Check

_____ Radiographs

_____ Oral Prophylaxis

_____ Fluoride Treatment

_____Restorations

The following statements are applicable:

_____all necessary services have been performed.

_____no restorative services are required at this time.

_____further treatment is indicated.

_____further appointments have been arranged.

Comments: _____
_____
_____
_____

_____
Dentist's Signature Date

PHYSICIAN'S REPORT

IMMUNIZATIONS

	Date	Date	Date	Date	Date
DPT					
Td					
Polio					
MMR					
HBV					
Varicella					
Hib					
Pnu					

SCREENING TESTS

	Date	Result	
Muscle Balance			
Farsightedness			
Color			
Distance Acuity		Right	Left
Hearing			
	Date	Test	Result
Tuberculin			

_____

Check one:

☐ Entirely within normal limits

☐ Abnormalities as follows:

Is there any reason why the student cannot carry out a full program of school work?

_____ Yes _____ No

_____
Physician's Signature Date

PHYSICAL ASSESSMENT

School Health Examination Record

GRADE: _____

1. Please complete:

Child's Name		Birth Date		Home Address		Home Phone	
Father's or Guardian's Name		Place of Employment		Business Phone			
Mother's Name		Place of Employment		Business Phone			
Physician's Name		Address:		Office Phone			

2. Is there anything about your child that the teacher needs to know to understand him better?

_____

_____

_____

_____

3. List diseases and other serious illnesses, injuries, or health conditions our child has had and give dates (year only):

_____

_____

_____

_____

4. Does any relative or anyone in the home have tuberculosis, diabetes, or other illnesses? Describe:

_____

_____

_____

_____