FAIR HAVEN PUBLIC SCHOOLS

Physical Examination Report for New Students

				Examination Date			
Child's Name		Male _	Female _	Birth Date		Day	
Address		Phone	e		Month		
TO BE COMPLETED E	BY FAMILY PHY	SICIAN:					
Height	Weight	B.P	Pu	ılse			
Eyes: Right		Ears Right					
Eyes: Left		Ears Left		_			
Nose		Abdomen					
Teeth		Genito Urinary					
Speech		Extremities					
Throat							
Neck		Posture					
Heart		Skin					
		Nutrition					
Lungs		elated physical activity:					
Lungs Do you prescribe any restr IMMUNIZATIONS:	rictions on school-re	elated physical activity: Yes I (month, day, year)	If yes, lis	st your recomr	mendations		
Lungs Do you prescribe any restr	Date Administered	elated physical activity: Yes N d (month, day, year) 2	If yes, lis	st your recomr	mendations o		
Lungs Do you prescribe any restr IMMUNIZATIONS: D.P.T. Series	Date Administered 1 4	elated physical activity: YesN d (month, day, year) 2 on or after 4th birthday	If yes, list	st your recomr	mendations o	on reverse	e side.
Lungs Do you prescribe any restr IMMUNIZATIONS: D.P.T. Series D.P.T. Booster	Date Administered 1 4 1	elated physical activity: Yes N d (month, day, year) 2 on or after 4th birthday 2 2	If yes, lis	st your recomr	mendations o	on reverso	e side.
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NOTE:Information reported on this form should be reflective of a physical exam conducted within one (1) year of admission.