THE BALDWIN SCHOOL WELLNESS CENTER
701 MONTGOMERY AVENUE, BRYN MAWR, PA 19010 610-525-2700

Name of Student: ______________________ Date of Birth: ____/____/____

Graduation Year ______________ Date of Exam: ____/____/____

Address: ______________________ City: ______________ State: ____ Zip: ________

IMMUNIZATION STATUS

*Immunizations are required before entrance to school. Students may not participate in sports until the physical examination form is complete and on file at school.

NOTE
For returning students: We have dates of initial series: document only boosters given since last year's exam.

Vaccine (doses)	Enter month, day & year (please give exact dates) each immunization was given				
Diphtheria and Tetanus DTaP, DTP, Td or DT)	1	2	3	4	5
Tetanus,Diphtheria and Acellular Pertussis (Tdap)*	1	2	3	4	5
Polio	1	2	3	4	5
Hepatitis B	1	2	3	4	5
Measles-Mumps-Rubella (MMR)	1	2	or Measles Serology Date Titer		
Varicella (Vaccine or Disease)	1	2	Rubella Serology Date Titer		
Meningococcal (MCV)*	1	2	Mumps disease diagnosed by a physician: Date		
Other	1	2			

* Age appropriate dose of MCV and Tdap are required for entry into 7th grade.

HEALTH HISTORY (Give Dates, if Known)

Allergy ______________________ Seizure Disorder ______________________

Asthma ______________________ Diabetes ______________________

Drug Allergy ______________________ Heart Disease ______________________

Give significant details of child's medical history, including serious illness, operations, accidents, etc. ______________________

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REPORT OF EXAMINATION

Date of Examination: ____/____/____ Height ________ Weight: ________ BMI%: ________ B/P: ________ Pulse: ________

	Normal	Abnormal		Normal	Abnormal
Emotional Status	( )	( )	Teeth	( )	( )
General Nutrition	( )	( )	Glands	( )	( )
Skin	( )	( )	Heart	( )	( )
Eyes	( )	( )	Lungs	( )	( )
Glasses: Contact Lens: R: L:			Abdomen	( )	( )
Ears	( )	( )	Neuro-muscular	( )	( )
Hearing	( )	( )	Speech	( )	( )
Nose & Throat	( )	( )	Skeleton	( )	( )

	Normal	Abnormal
Posture	( )	( )
Scoliosis (bending position)	( )	( )

Is student under observation for or treatment of scoliosis?
Explain:

Is child under treatment? Yes ( ) No ( ) Should this child have restrictions on play, physical education or sports activities? Yes ( ) No ( )

Medical Diagnosis/Restrictions: ______________________

Medications prescribed: ______________________

Signature of Physician ______________________ Date ______________

Print name of Physician ______________________ Telephone ______________