

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					
	1	2	3	4	5	
Diphtheria and Tetanus DTaP, DTP, Td or DT)						
Tetanus, Diphtheria and Acellular Pertussis (Tdap)*						
Polio						
Hepatitis B						
Measles-Mumps-Rubella (MMR)			or Measles Serology		Date	Titer
Varicella (Vaccine or Disease)			Rubella Serology		Date	Titer
Meningococcal (MCV)*			Mumps disease diagnosed by a physician: Date			
Other						

* 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. _____

REPORT OF EXAMINATION

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

	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Emotional Status	()	()	Teeth	()	()	Posture	()	()
General Nutrition	()	()	Glands	()	()	Scoliosis (bending position)	()	()
Skin	()	()	Heart	()	()		()	()
Eyes	()	()	Lungs	()	()	Is student under observation for or treatment of scoliosis?		
Glasses: Contact Lens: R: L:			Abdomen	()	()	Explain:		
Ears	()	()	Neuro-muscular	()	()			
Hearing	()	()	Speech	()	()			
Nose & Throat	()	()	Skeleton	()	()			

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 _____