

**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 7<sup>th</sup> 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 \_\_\_\_\_