

**WESTCHESTER DAY SCHOOL  
PHYSICAL EXAMINATION CERTIFICATE**

PLEASE return this report to your School Nurse as soon as the examination has been completed. **All reports must be in by Sept. 30<sup>th</sup>.**  
A physical examination done anytime within the last 12 months is acceptable. **PHYSICAL EXAMS MUST BE DONE FOR GRADES  
K,, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup> AND ALL NEW STUDENTS** (as required by N.Y. State Health Law).

NAME: \_\_\_\_\_ School year: September: \_\_\_\_\_ (year)

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

**PHYSICIAN'S HEALTH EXAMINATION CERTIFICATE  
TO BE COMPLETED & SIGNED BY PHYSICIAN/PRACTITIONER**

**HEALTH HISTORY:**

Allergy (drugs): _____ (food): _____ (other): _____	Medications taken now: _____
Asthma: _____ Inhaler: _____ Nebulizer: _____	Menses - Date of Onset _____ Frequency: _____
Chickenpox: _____	Pneumonia: _____
Diabetes: _____	Severe injury: _____
Ear infections: _____	Speech: _____
Epilepsy: _____	H/o Substance abuse: _____
Frequent colds/sore throats: _____	Alcohol consumption: _____ Frequency: _____
Hearing: _____	Tobacco use: _____ Frequency: _____
Heart disease: _____	Surgeries: _____
Lead exposure _____	TB (self): _____ TB (family member): _____
Lyme disease: _____	Vision Problem: _____
	Glasses: _____ Contacts: _____
	Other: _____

**PHYSICAL EXAMINATION:** REVEALS THE FOLLOWING (Please include test results such as hearing, vision, lab results, etc).

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **BP:** \_\_\_\_\_ / \_\_\_\_\_

**VISION SCREENING:** 20/\_\_\_\_; 20/\_\_\_\_ **AUDIOGRAM:**  Pass (20 dB @ 1000, 2000 & 4000 Hz)  Fail

Eyes: _____	Abdomen: _____
Ears: _____	Genito-urinary: _____
Nose: _____	Hernia: _____
Lymph nodes: _____	Neurological: _____
Thyroid: _____	Nutrition: _____
Tonsils & Adenoids: _____	Orthopedic: _____
Teeth: _____	Skin: _____
Heart: _____	Other: _____
Lungs: _____	<b>SCOLIOSIS:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive _____ degree of curvature

**GENERAL PHYSICAL & EMOTIONAL STATUS:** \_\_\_\_\_

**ILLNESSES & OPERATIONS:** \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL EDUCATION ACTIVITIES:** YES \_\_\_\_\_ NO \_\_\_\_\_ (If no, please submit a separate medical note listing diagnosis & activities in which student may or may not participate).

**OFFICE STAMP NECESSARY HERE** ↓

Examiner's Name \_\_\_\_\_ SIGNED: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

*SIGNATURE INDICATES THAT THIS CHILD HAS BEEN EXAMINED BY THE ABOVE PHYSICIAN/PRACTITIONER AND HAS  
BEEN FOUND IN GOOD PHYSICAL CONDITION TO ATTEND SCHOOL AND PARTICIPATE IN ALL SCHOOL RELATED ACTIVITIES.*  
9/06