

The Hayground School
151 Mitchells Lane, PO Box 1827, Bridgehampton, NY 11932
Telephone: (631) 537-7068 Fax: (631) 537-5195

PHYSICAL EXAMINATION AND IMMUNIZATION RECORD

To be completed by physician

Student's Full Name _____ Sex ____ Birth date _____

Address _____

Height: Ft./In. _____ Weight _____ Posture _____

Condition of:

Skin _____

Ears _____

Nose _____

Throat _____

Tonsils _____

Thyroid _____

Heart _____

Pulse _____

BP _____

Teeth _____

Eyes: R _____ L _____

Glasses _____

Nervous System _____

Laboratory:

Hemoglobin _____

Urinalysis:

Albumin _____ Sugar _____

Allergic Condition:

Hay Fever _____ Asthma _____

Drug Allergies _____

Food Allergies _____

Immunizations: Please list dates.

DPT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Sablin Polio 1. _____ 2. _____ 3. _____ 4. _____

Measles 1. _____ 2. _____

Mumps. 1. _____ MMR 1. _____ 2. _____

Rubella 1. _____ HIB 1. _____ 2. _____ 3. _____ 4. _____

Varicella 1. _____ 2. _____ Hep B 1. _____ 2. _____ 3. _____

Tuberculin Test: (within 12 Months) _____ Results _____

Is there any physical, emotional or health problem not mentioned about which the school should be informed? If so, explain.

Is the student currently under any medical treatment? _____ if yes, please specify:

Physician's Signature _____

Address _____

Telephone _____ Date _____