De Soto Area Schools
Physician's Student Physical Report Form

Child's Name _____ DOB _____

Parents _____

Street Address _____

City _____ ZIP _____ Telephone _____

1. B/P _____ Pulse _____ Respiratory_____
   Weight _____ Height _____

   General Appearance _____

   Skin_____ Lymph nodes_____

   Head _____ Eyes _____

   Ears _____ Mouth _____

   Neck _____ Throat _____

   Thorax _____ Lungs _____

   Heart _____ Abdomen _____

   Genitalia _____ Rectum _____

   Extremities _____ Neurological problems _____

2. Vision Screen _____ Hearing Screen _____

3. Lab tests: HGB _____ Urinalysis _____

4. Immunizations at time of this physical:
   M.M.R _____ D.P.T. _____ Polio _____
   Hep. B. _____ Varicella _____

   Is the child now up to date with their immunizations? YES NO

5. Doctor: Is there anything not mentioned above that the school nurse or teachers should be aware of? _____

   _____

   _____

Print Physician's name _____ Clinic_____

Physician's signature _____Date of the exam _____