

Brentwood School District  
 90 Yorkshire Lane  
 Brentwood, MO 63144

Physical Examination Report

Student Name \_\_\_\_\_ M/F \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_ Address \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
 (parents complete this top portion)

The Brentwood Board of Education Policy requires all students entering Kindergarten and those new to the district to have a physical examination within the current calendar or school year. The board requests examinations at the beginning of 4<sup>th</sup>, 7<sup>th</sup>, and 10<sup>th</sup> grades.

**Missouri Required Immunizations**

Diphtheria, Pertussis, Tetanus      Polio      Measles, Mumps, Rubella      Hepatitis B      Chickenpox  
 (DPT/Td/Dtap)      (IPV/OPV)      (MMR)      (HepB)      (Varivax/etc.)

Evidence of physical examination and immunizations must be given to school. At time of exam, please ask that this form be completed. Please bring or mail to school. Thank you for your cooperation.

Dr. C. Penberthy, Superintendent \_\_\_\_\_ Principal

Significant medical history (give dates where possible)

Asthma \_\_\_\_\_ Accident \_\_\_\_\_ Allergies \_\_\_\_\_  
 Frequent ear infections \_\_\_\_\_ Tubes \_\_\_\_\_ Surgery \_\_\_\_\_  
 Heart problem \_\_\_\_\_ Other \_\_\_\_\_  
 Routine medicines \_\_\_\_\_ Given for \_\_\_\_\_

Immunizations (please indicate which is given; give month/day/year)

DTP/DTaP/Td	OPV/IPV	Hepatitis B	MMR	HIB	Other	TB test/results
		Hepatitis A	Chickenpox			

Examination (please check or mark for within normal limits or describe)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
 Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Tonsils \_\_\_\_\_  
 Mouth \_\_\_\_\_ Teeth & Gums \_\_\_\_\_ Lymph nodes \_\_\_\_\_ Skin & Hair \_\_\_\_\_  
 Heart \_\_\_\_\_ Heart Rate \_\_\_\_\_ Lungs \_\_\_\_\_ Abdomen \_\_\_\_\_  
 Neurological \_\_\_\_\_ Orthopedic \_\_\_\_\_ Posture \_\_\_\_\_ Nutrition \_\_\_\_\_  
 If tested Vision: Right \_\_\_\_\_ Left \_\_\_\_\_ Both \_\_\_\_\_ Hearing Right \_\_\_\_\_ Left \_\_\_\_\_  
 Details on positive findings \_\_\_\_\_ Recommendations \_\_\_\_\_  
 Should activity be restricted? No \_\_\_\_\_ Yes \_\_\_\_\_ Degree of restriction \_\_\_\_\_  
 Comments \_\_\_\_\_

\_\_\_\_\_  
 (Printed name and signature of examiner)

\_\_\_\_\_  
 (Date)

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