

**The American International School - Pre-School  
New Student Physical Examination Form / School Year 200\_\_\_ - 200\_\_\_**

**To be completed by physician**

**\*\* It is very important to bring the student's official immunization record to the physician's office on the day of the exam.**

Student's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Eyes: Glasses \_\_\_\_ Contact lens \_\_\_\_

Skin/Appearance
Eyes/Ears/Nose/Throat
Lymph Nodes
Heart
Pulses
Lungs
Abdomen
Neurological
Nutrition
Back -Scoliosis check: + or -

**Health History**

Previous Illnesses \_\_\_\_\_

Allergies \_\_\_\_\_ Surgery \_\_\_\_\_

Chronic Conditions \_\_\_\_\_

Physical Limitations \_\_\_\_\_

Any restrictions to full participation in physical education classes? Yes  No

Please explain if Yes: \_\_\_\_\_

**Immunizations**

*Students must be immunized according to the recommended Childhood Immunization Schedules of the United States and Israel (see USA schedule on back - Israeli schedule is comparable).*

Examining physician - after reviewing immunization record, please record any inoculations or tests needed or given at the time of this exam:

DTP or DT \_\_\_\_\_ MMR (measles, mumps, rubella) \_\_\_\_\_

POLIO (specify OPV or IPV) \_\_\_\_\_

Other \_\_\_\_\_

Tuberculin Test (Mantoux) \_\_\_\_\_ Result \_\_\_\_\_

**Date of Exam** \_\_\_\_\_

**Physician's Signature** \_\_\_\_\_

**Physician's Phone #** \_\_\_\_\_

## Recommended Childhood and Adolescent Immunization Schedule -- United States, 2003

Vaccine	Age	range of recommended ages				catch-up vaccination				preadolescent assessment			
		Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	13-18 yrs
Hepatitis B <sup>1</sup>		HepB #1	HepB #2		HepB #3				HepB series				
Diphtheria, Tetanus, Pertussis <sup>2</sup>			DTaP	DTaP	DTaP		DTaP			DTaP	Td		
<i>Haemophilus influenzae</i> Type b <sup>3</sup>			Hib	Hib	Hib	Hib							
Inactivated Polio			IPV	IPV	IPV					IPV			
Measles, Mumps, Rubella <sup>4</sup>						MMR #1				MMR #2	MMR #2		
Varicella <sup>5</sup>						Varicella			Varicella				
Pneumococcal <sup>6</sup>			PCV	PCV	PCV	PCV			PCV	PPV			
Vaccines below this line are for selected populations													
Hepatitis A <sup>7</sup>									Hepatitis A series				
Influenza <sup>8</sup>					Influenza (yearly)								

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2002, for children through age 18 years. Any dose not given at the recommended age should be given at any subsequent visit when indicated and feasible.   Indicates age groups that warrant special effort to administer those vaccines not previously given.   Indicates age groups that warrant special effort to administer those vaccines not previously given. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.