Towle Institute
Student Physical Form

To be completed by licensed medical physician, nurse practitioner or physician's assistant

[ ] Returning Student [ ] New Student

Name: ____________________ Sex: ________ DOB: ____________________

Address: ____________________ Phone: ____________________

____________________ Grade: ____________________

____________________ Today's Date: ____________________

Examiner's Name: ____________________ Phone: ____________________

PLEASE CHECK IF CHILD HAS HAD DIFFICULTY WITH ANY OF THE FOLLOWING:
GIVE DATES AND ADDITIONAL INFORMATION UNDER COMMENTS.

[ ] ADD/ADHD
[ ] Allergies
[ ] Asthma
[ ] Behavior
[ ] Bleeding
[ ] Body Piercing/Tattoo
[ ] Bone Problem
[ ] Bowel/Bladder
[ ] Chicken Pox
[ ] Diabetes
[ ] Emotional
[ ] Hearing
[ ] Heart
[ ] Infections
[ ] Kidney
[ ] Physical Disability
[ ] Seizures
[ ] Speech
[ ] Surgery
[ ] Vision
[ ] OTHER ____________________

Comments: ____________________

____

Height: ________ Weight: ________ Blood Pressure: ________ Pulse: ________

Vision: Right ________ Left ________

Hearing: Right ________ Left ________

Lead Screening: Date Completed ________ Results ________

Hematocrit/Hemoglobin: Date Completed ________ Results ________

PPD(Mantoux): Date Placed ________ Date Read ________ Results (in mm) ________

OR Results of TB risk assessment ____________________

Immunizations - Vaccines Required in **Bold Print**

DTP/DtaP / /	**DTP/DtaP** / /	**DTP/DtaP** / /	**DTP/DtaP** / /	**DTP/DtaP** / /
OPV/IPV / /	**OPV/IPV** / /	**OPV/IPV** / /	**OPV/IPV** / /	OPV/IPV / /
PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /	PCV7/PCV13 / /
Hib / /	Hib / /	Hib / /	Hib / /	
MMR / /	**MMR** / /	**HepB/HepB-2** / /	**HepB/HepB-2** / /	**HepB** / /
Varicella 1 / /	**Varicella 2** / /	RV-2/RV-3 / /	RV-2/RV-3 / /	RV-3 / /
Varicella 1 / /	**Varicella 2** / /	Lyme Vax 1 / /	Lyme Vax 2 / /	Lyme Vax 3 / /
MCV4 / /	MCV4 / /	HPV / /	HPV / /	HPV / /
Hep A / /	Hep A / /	**Td/Tdap** / /	Td/Tdap / /	Td / /
Influenza / /	Influenza / /	PPSV23 / /	PPSV23 / /	
Other / /	Other / /	Other / /	Other / /	Other / /

OVER

Patient's name: ______________________

Physical Exam	Normal	Abnormal	Comments
General Appearance			
Head/Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth/Gums			
Heart			
Chest/Lungs			
Skin			
Abdomen			
Genitalia			
Neurological			
Developmental			
Musculoskeletal			
Nutrition			

Health problems or special needs identified:

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List any medications taken on a regular or as needed basis:

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FOR CHRONIC CONDITIONS

Attach care plan, protocols, and/or emergency care plan.

Recommendations or Referrals:

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Examiner's Signature: ______________________________ Date: __________

Printed Name: ______________________________

☐ Physician (MD or DO) ☐ Clinical Nurse Specialist (APN)

☐ Advanced Practice Nurse (APN) ☐ Physician Assistant (PA)

Address: ______________________________ Phone #: ______________

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