Towle Institute
2024-25 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	[ ] Body Piercing/Tattoo	[ ] Emotional	[ ] Physical Disability
[ ] Allergies	[ ] Bone Problem	[ ] Hearing	[ ] Seizures
[ ] Asthma	[ ] Bowel/Bladder	[ ] Heart	[ ] Speech
[ ] Behavior	[ ] Chicken Pox	[ ] Infections	[ ] Surgery
[ ] Bleeding	[ ] Diabetes	[ ] Kidney	[ ] 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:

_____

_____

_____

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

_____

_____

_____

FOR CHRONIC CONDITIONS

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

Recommendations or Referrals:

_____

_____

_____

_____

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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