Assumption Academy

Physician Questionnaire K-8

(This form must be completed and signed by your Physician)

Name:_____ **Birth Date:**_____
Last First

Address:_____
Street City Zip Code

EXAMINATION

Height:_____ **Weight:**_____

Eyes:_____ **Vision: R. 20/**_____ **L. 20/**_____

Ears:_____ **Hearing Test - Type:**_____ **R.**_____ **L.**_____

Referred to ear or eye specialist? Yes No

Nose:_____ **Throat:**_____

Mouth:_____ **Teeth:**_____

Is dental work indicated? Yes No **If so, are plans being made? Yes No**

Posture:_____ **General Condition:**_____

Skin:_____ **Orthopedic:**_____

Neck:_____ **Nervous System:**_____

Heart:_____ **Lungs:**_____

Abdomen:_____ **Hernia:**_____

Genitalia:_____ **Urinalysis:**_____

Allergies:_____

Remarks/Recommendations:_____

IMMUNIZATIONS (Please include month/day/year)

DTP: 1st_____ 2nd_____ 3rd_____ 4th_____

DTP/DTaP4: _____ **DTP/DTaP5:** _____

Booster: Td:_____ -OR- Tdap: _____

Polio Vaccine (OPV/IPV): 1st_____ 2nd_____ 3rd_____ 4th_____

MMR-1: _____ **MMR-2:** _____

Hib (Haemophilus B): 1st_____ 2nd_____ 3rd_____ 4th_____

Hepatitis B: 1st_____ 2nd_____ 3rd_____ 4th_____

Varicella Vaccine: 1st_____ 2nd_____ 3rd_____ 4th_____

Tuberculin Test: Date:_____ Results:

MCV4 (Meningococcal) 1st_____ 2nd_____

_____
Physician Signature **Date of Exam**