SPORT: ______________________

Bay Shore Union Free School District

Peter J. Dion, Superintendent of Schools

Private Physician's Report of Student Medical Examination

LAST** Name* ______________________________ ***FIRST **Name** ____________________ **DOB** ____________

Address____**School** ____________**Grade**______**Sex**_______

☐ ***Immunization record attached*** **Immunizations and Dates**

	Date	Date	Date		Date	Date	Date	Date	Date
MMR				**DTaP**					
Varicella				**Hib**					
Hepatitis A				**Polio**					
Tdap				**Hepatitis B**					
Td/Dt				**Pneumococcal**					
HPV				**Meningococcal**					
				Tuberculin Test					

Height ______ **Weight**: ________ **Blood Pressure:** ___________

Body Mass Index: _____ _____. ______

Weight Status Category (BMI Percentile):

Vision - [R] 20/_____ [L] 20/_____ with / without glasses

☐ **less than 5th** ☐ **5th through 49th** ☐ **50th through 84th**

Hearing - ☐ **pass 25 dcb sc both ears or: [R[_____[L] ______**

☐ **85th through 94th** ☐ **95th through 98th** ☐ **99th and higher**

☐ **EXAM ENTIRELY NORMAL** UA: ____________ Scoliosis: __________

Specify any abnormality: ____

☐ Allergies**:** ___________________________________ ☐ **Asthma**: __________

☐ Medication**:** ____

Recommendations: Full activity/Sports/PE: ☐

Modified activity/Restrictions: ☐ _____________________________________

A complete physical examination of this patient has been performed on (date) : ____________________

Provider's signature: ________________________ **Provider's stamp: (*required*)**

H27 (4/11)