Columbia Grammar & Preparatory School, 5 W. 93rd Street, NY, NY 10025

ANNUAL MEDICAL EXAM FORM

(To be completed by HEALTH CARE PROVIDER)

Health Care Provider May Use Own Form BUT CONSENT BELOW MUST BE SIGNED

Student's Name____**Grade**________ **Date of Birth**____________

Significant past illness or injury including allergies, surgery and chronic conditions:

____

Current medical problems: ____

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
Diphtheria and Tetanus toxoid-containing vaccine and Pertussis vaccine (DTaP/DTP/Tdap)						
Tetanus and Diphtheria toxoid-containing vaccine and Pertussis vaccine booster (Tdap)						
Polio vaccine (IPV/OPV)						
Measles						
Mumps						
Rubella						
Or Measles, Mumps and Rubella vaccine (MMR)						
Hepatitis B vaccine						
Varicella (Chickenpox) vaccine						
Meningococcal conjugate vaccine (MenACWY)						
Haemophilus influenzae type b conjugate vaccine (Hib)						
Pneumococcal Conjugate vaccine (PCV)						
PPD test/Mantoux	Date		Result			

Blood Pressure ___________ **Pulse** ________ **Height** ________ **Weight** _______ **BMI**________**Scoliosis**________
Vision Screening: Rt.__________ **Lt.**__________ **Hearing: Rt.** __________ **Lt.** _______

ACTIVITY: Full ❑ Limited ❑ Please explain: ____

LEAD ASSESSMENT (Under 6 annually):____

HEALTH CARE PROVIDER CONSENT FOR ACTIVITIES & MEDICATION ADMINISTRATION

I have examined this student and have found his/her physical exam within normal limits. He/she is physically fit to participate in Physical Education classes and/or sports. I give my permission for the school nurse to administer over-the-counter medications indicated by parents according to package directions.

SIGNATURE OF HEALTH CARE PROVIDER______________________________ **DATE OF EXAM:** ________

Health care provider Name (please print or stamp): ____

Address and Telephone number: ____