PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT PLAINVIEW, NEW YORK 11803

MEDICAL REPORT

Name	Date of Birth
Addre	SS
Phone	<u>. </u>
	Signature of Applicant Date
<u>Appli</u>	cant:
1.	Do you have or have you ever had: Chicken Pox Fifth's Disease German Measles
2.	Do you have or have you ever had:
	Heart Disease
Please	Explain Items Checked:
3.	Have you traveled outside the United States since your last visit to a physician? Yes No Where
4.	Are you or have you ever taken any daily medications for more that 14 days? Yes No
	If yes, please list:
5.	Do you have any medication allergies? Yes No
	If yes, please list:
6.	List the dates of your last: Chest X-Ray Tetanus Toxoid Immunization TB Skin Test Tetanus Toxoid Immunization
	Tine Mantoux
7.	Are you a smoker? (Reply optional)

PHYSICIAN

Examination:						
Appearance						
Vital Signs		BP:	Pulse:	Resp:		
Skin			Breasts			
Head			Ext. Genitalia			
Eyes			Back			
Nose			Lymph Nodes			
Throat			Extremities			
Neck			Neurologic			
Lungs			Teeth			
Heart			Speech			
Abdomen			Nutrition			
Physician's Co						
Date of Examination						
Physician's Name						
Physician's Sig	gnature			Date		
Physician's Address						