New Springs Christian Academy
Physical Examination Report

2025-2026 School Year

Student Name_____ Grade_____

Parent(s) Name_____ Date of Birth_____

Address_____ Phone_____

Medical Conditions of Concern to School Personnel:

Any Physical Limitations or School Activity Restrictions:

Prescribed Medications:

Vision R 20/_____ L 20/_____

Hearing R ear_____ L ear_____

Immunizations: List all immunizations given to date, including infant immunizations.

DTP/DtaP/DT/Td	1.	OPV/IPV	1.	MMR	1.	Hepatitis B	1.
DTP/DtaP/DT/Td	2.	OPV/IPV	2.	MMR	2.	Hepatitis B	2.
DTP/DtaP/DT/Td	3.	OPV/IPV	3.	HIB	1.	Hepatitis B	3.
DTP/DtaP/DT/Td	4.	OPV/IPV	4.	HIB	2.	TB Test/Result	
DTP/DtaP/DT/Td	5.	OPV/IPV	5.	HIB	3.	Varicella Vaccine	
Td Booster				HIB	4.	Chicken Pox Disease	

I would like the teacher to contact me regarding this child. (if applicable, circle) YES

Physician's Name – (please print): _____

Date of Examination_____ Examining (child's name): _____

Physician's Signature: _____

Phone_____

Address_____

Please return to New Springs Christian Academy
600 Elm St. Neenah, WI 54956