

HEALTH EXAMINATION RECORD (To be completed by your child's Physician. If your child is currently enrolled, a copy of this form is on file with the school nurse but may need to be updated.)

Child's Name _____ Birthdate _____ Grade Entering _____

Home Address _____

City _____ State _____ Zip _____

Please list diseases and other serious illness, injuries or health conditions pertaining to this child and give dates (year only):

Allergies: _____

Physician's Report

IMMUNIZATIONS	Date	Date	Date	Date	Date
DTap					
Td					
Polio Sabin (Tri)					
MMR					
Measles					
Rubella					
Mumps					
Hepatitis B					
HIB					
Varicella					

Physician must complete bottom portion of this form for all Pre-K and Kindergarten students and for all 1st-8th grade students who are new enrollees.

Physical Assessment: Check One:

_____ Entirely within normal limits.

_____ Abnormalities as follows

The student is physically able to carry out a full program of school work and all athletics. ___ Yes ___ No
If no, state reason:

Signature of Examining Physician _____

Date _____

Office Phone _____