

Christ Community Lutheran School

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IMMUNIZATION AND HEALTH INFORMATION for all students PHYSICIAN'S EXAM FORM for kindergarten, 4th grade, 7th grade, and all new students.

Student:	Grade:	Date of Birth:			
Address:		Home Phone:			
Parent/Guardian:					
HEALTH HISTORY – TO BE COMPLETED BY PARENT Has child ever had any of the following? (<i>circle</i>) If yes, please explain. Asthma Y N Epilepsy Y N Diabetes Y N Chicken Pox Y N Other Serious Illness Y N Surgeries Y N Allergies Y N Medications (current or past) Y N Has child ever been advised to restrict activity in the last 5 yrs? Y N		IMMUNIZATIONS (<i>Give month, day & year</i>)			
		HIB			
		DPT			
		DT BOOSTER			
		POLIO			
		MMR		RUBELLA	
		TINE/PPD			
		HEP B			
		Chicken Pox			
		OTHER			
ORTHOPEDIC HISTORY Head injury Y N Neck/Back Y N Hip/Leg/Foot Y N Other Serious Y N					

TO BE COMPLETED BY PHYSICIAN (for students entering Kindergarten, 4 th & 7 th grade, and NEW students)				
Is this child under care at this time? Y N				
PHYSICAL FINDINGS		For NEW Students:		
Height:	Weight:	RECOMMENDATION FOR SCHOOL Special seating recommended: Medical treatment at school:		
B/P:	Pulse:			
Eyes:				
Snellen:	Cover Test:			
ENT:	Heart:			
Chest/Lungs:	Abdomen:			
Hernia:	Lymph Nodes:			
Neurologic:	Genitalia:			
	Scoliosis:			
Name of Examiner (<i>please print</i>):				
Signature of Examiner:		Date:	Phone Number:	
Address:				

I give consent and authorize the school to obtain, through a physician of its choice such as medical care as is reasonably necessary for the welfare of the student, if she/he is injured in the course of school activities. I also give consent for the school nurse or administrator to contact child's physician concerning health issues.

 Parent/Guardian Signature

 Date