5/8/2014

EASTERN CHRISTIAN SCHOOL

PHYSICAL EXAMINATION REPORT

(Due before the first day of entrance to school)

Student's Name: _____ Phone: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Sex: _____ Grade Level in September: _____

Mother's Name: _____ Father's Name: _____

Address:_____ Address: _____

_____ _____

Phone: _____ Phone: _____

New Student from: _____
(School) (City) (State)

Student's Medical History

(To be completed by Parent or Physician)

	YES	NO	Description/Reason
Allergies			
Asthma			
Blood Disorders			
Cancer			
Chicken Pox			
Diabetes			
Headaches			
Hearing Problems/Hearing Aide			
Heart Disease			
Anxiety/Depression			
High/Low Blood Pressure			
Hospitalizations			
Kidney/Urinary Tract Problem			
Medication Reactions			
Menstrual Disorder			
Mononucleosis			
Muscular Disorder			
Orthopedic Disorder			
Rheumatic Fever			
Scoliosis			
Seizure Disorder			
Strep Infections			
Surgery			
Ulcer/Gastrointestinal Disorder			
Visual Problem/Glasses/Contact Lenses			
Other			

Is the student now under the care of a physician? _____

Does the student take any regular medication? Please name medication and dosage: _____

_____

Has the student ever been advised by a physician not to play a sport? _____

Are there any other physical or emotional conditions that might affect this child's abilities or performance? _____

COMMENTS: _____

TO BE COMPLETED BY PHYSICIAN

Student's Name: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision without Correction: R20/_____ L20/_____ Both 20/_____

Vision with Correction: R20/_____ L20/_____ Both 20/_____

Hearing: Right: _____ Left: _____

Nutrition (Please note significant weight gain or loss in the last year): _____

Head & Neck: _____ Lungs: _____ Extremities: _____

Nose: _____ Heart: _____ Neurological: _____

Eyes: _____ Abdomen: _____ Urinalysis: _____

Ears: _____ Back: _____ Hemoglobin: _____

Throat: _____ Genitalia: _____ Scoliosis Screening: _____

If positive, Treatment? _____

Chest/Breast: _____ Hernia: _____

Comments: _____

- **Based on this history/physical, this student:**

  _____may participate in competitive athletics and physical education activities.

  _____has health problems, which prohibit participation in the following athletic activities: _____

  _____

A. **New Students:** Complete information for all immunizations must be submitted. Please include month, day and year for each immunization.
Returning Students: Please note date of last booster and any other immunization that has been given in the last year.

VACCINE TYPE	1ST Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Hr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
Diptheria, Tetanus, Pertussis – (DTaP) *If Td or DT, write in corner box)							
Tdap (not Td)							
Polio-Inactivated Vaccine (IPV) If oral polio, write (OPV) in corner box							
MMR (Measles, Mumps & Rubella					Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Haemophilus B (HIB)**					Hepatitis B	Date:	Titer:
Hepatitis B					Varicella	Date:	Titer:
Varicella					Measles	Date:	Titer:
Pneumococcal Conjugate**					Mumps	Date:	Titer
Meningococcal (Meningitis (ACYW)					Rubella	Date:	Titer:
Hepatitis A***							
Influenza**							
HPV (Human Papillomavirus)**							
Other (Specify)							
*DT Requires valid medical exemption **Required for Day/Child Care (2m-5yo)	Medical exemption attached ☐ *** Not Required			Religious exemption attached ☐ Provisional admissions attached ☐ Date Granted:			

B. **Mantoux Tuberculin Test:** Date:_____Result:_____If positive, did student have chest X-ray?_____Result?_____

Physician's Signature: _____ **Date of Examination:** _____

Physician's Name: _____ **Address:** _____

_____ **Telephone:** _____