



Immaculate Conception Catholic School Immunization & Health Information Form 2017-2018

Physicians Exam Form For Kindergarten, 3RD, 6TH GRADERS & New Students

Student	TO BE COMPLETED BY PHYSICIAN IMMUNIZATIONS (Give month, day and year) HIB _____ DPT _____ DT Booster _____ Polio _____ MMR _____ Rubella _____ Tine/PPD _____ HepB _____ Chicken Pox (Varicella) _____ Other _____	TO BE COMPLETED BY PHYSICIAN RECOMMENDATION FOR SCHOOL Special seating recommended Medical Treatment at School
Address		
Grade Sex (circle) M F		
Date of Birth		
Parent/Guardian	TO BE COMPLETED BY PHYSICIAN (For students entering Kindergarten, 3 rd grade, & 6 th grade or new to the school) Is this child under care at this time? Y N PHYSICAL FINDINGS Height Weight B/P Pulse Eyes: Snellen Cover test ENT Chest/Lungs Heart Abdomen Hernia Lymph Nodes Genitalia Neurology Scoliosis	ORTHOPEDIC EXAM (for sports participation) ROM Back Neck/Shoulders Upper Extremities Lower Extremities RECOMMENDATION FOR SPORTS (mark one) _____ Full unlimited participation _____ No participation _____ Limited participation _____ Clearance withheld until _____
Home Phone	TO BE COMPLETED BY PARENT – TO BE COMPLETED BY PARENT - Has child ever had any of the following? (circle) 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	Name of Examiner (please print)
Work Phone		
Health History – TO BE COMPLETED BY PARENT - Has child ever had any of the following? (circle) 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	ORTHOPEDIC EXAM (for sports participation only) Head Injury Y N Neck/Back Y N Hip/Leg/Foot Y N Other Serious Y N	Date _____ Address _____ Phone _____ Fax Phone _____

Parent's or Guardian's Permission:

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

Parent Signature

Date