COMMUNITY CHRISTIAN SCHOOL

Physical Exam

Male ☐ Female ☐

Name: _____ Birthdate: _____

Last First Middle

Parent or Legal Guardian: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Does your child have any allergies to medication, food, etc? (Be specific)

Does your child have any special medical problems such as asthma, epilepsy, diabetes, etc? (Be specific)

Does your child take any medication? (Be specific)

PHYSICAL EXAMINATION: (To be completed by a physician)

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

	Normal	Abnormal Findings
Speech		
HEENT		
Mouth & Teeth		
Skin		
Heart		
Chest & Lungs		
Abdomen		
Back		
Extremities		
Genitals		
Musculoskeletal: ROM		
Neurological		
Urine Analysis		
Blood Work (specify test)		
Immunization Updates		

Defects or conditions that would have an effect on school performance:

Description of abnormalities or handicaps, specific recommendations and comments by Physician:

Physical Education Program: Full ☐ limited ☐

PRINTED NAME OF EXAMINING PHYSICIAN:

SIGNATURE OF EXAMINING PHYSICIAN:

11/12/2003

Date of Examination: _____