Christ Community Lutheran School

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Phone: (314)822-7774 Fax: (314)822-5472

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Phone: (314)961-6595 Fax: (314)5166

IMMUNIZATION AND HEALTH INFORMATION for all students
PHYSICIAN'S EXAM FORM

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? (*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

Has child ever been advised to restrict activity in the last 5 yrs? Y N

ORTHOPEDIC HISTORY
Head injury Y N
Neck/Back Y N
Hip/Leg/Foot Y N
Other Serious Y N

IMMUNIZATIONS (*Give month, day & year*)

HIB				
DPT				
DT BOOSTER				
POLIO				
MMR			**RUBELLA**	
TINE/PPD				
HEP B				
Chicken Pox				
OTHER				

TO BE COMPLETED BY PHYSICIAN (for students entering Kindergarten, 4th & 7th grade, and NEW students)
Is this child under care at this time? Y N

PHYSICAL FINDINGS	
Height:	Weight:
B/P:	Pulse:
Eyes:	
Snellen:	Cover Test:
ENT:	Heart:
Chest/Lungs:	Abdomen:
Hernia:	Lymph Nodes:
Neurologic:	Genitalia:
	Scoliosis:
Name of Examiner *(please print):*	

For NEW Students:
RECOMMENDATION FOR SCHOOL

Special seating recommended:

Medical treatment at school:

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