CAPE CHRISTIAN SCHOOL

PHYSICAL EXAMINATION AND HEALTH HISTORY FORM

This form is required for students in Grades Kindergarten, 3, and 7 and must be completed by your health care provider.

Student's Name (Last) _____ **(First)** _____ **Gender: M** ____ **F** ____ **Age** _____

Parent/Legal Guardian _____ **Grade** _____ **Birthdate** _____

Phone (H) _____ **(W)** _____ **Today's Date** _____

PARENT/LEGAL GUARDIAN: PLEASE COMPLETE THIS SECTION PRIOR TO SEEING PHYSICIAN

Health History – Enter Date	
Allergies (Specify)	**Chicken Pox: month** _____ **year** _____
Asthma	Rheumatic Fever
Bone/Joint Problems (Specify)	Serious Accidents (Specify)
Diabetes	Seizures
Measles	Heart Disease
Mumps	Other (Specify)
Rubella	

Current Health Concerns
(Specify)
Parent/Legal Guardian Signature:
Date: _____

PHYSICIAN: PLEASE COMPLETE THIS SECTION

Immunization History Enter Mo./Day/Yr.							
DTP/dT							
Polio							
Measles			Medical Exemption (Specify)				
Mumps							
Rubella							
HIB							
Varicella							
Hepatitis B							

Examination – Indicate Normal (N) or Abnormal (Ab). If Abnormal, include comments below			
Skin/Lymph		Lungs	
Eyes		Abdomen	
Ears		Genito-urinary	
Nose		Orthopedic	
Mouth		Scoliosis	
Throat		Neurological	
Neck		Speech	
Heart		Other (Specify)	

Test – Indicate Normal (N) or Abnormal (Ab) If Abnormal, include comments below		**Measurement Give Exact Value**	
Tuberculin		Blood Pressure	
Hemoglobin/Hematocrit		Height	
Urine		Weight	
		Vision: R20/ L20/ w/glasses Yes No	
		Hearing: R _____ L _____ w/hearing aid Yes No	

1. Physical activities should be restricted.
   No _____ Yes _____ If Yes, specify _____
   _____
2. There is a condition that may result in an emergency.
   No _____ Yes _____ If Yes, specify _____
   _____
3. There is a condition that may interfere with learning.
   No _____ Yes _____ If Yes, specify _____
   _____

On-going therapies and medications – specify type and dose

Problems as indicated above (Include restrictions on physical activities)

Plans and recommendations

Physician's Signature _____ Date of examination _____ Phone _____

Physician's Name _____ Address _____