

LAKE CENTER CHRISTIAN SCHOOL

DATE _____

PHYSICAL EXAMINATION FORM

GRADE _____

FAMILY INFORMATION

Name _____ DOB _____

SS# _____ Home Phone _____

Home Address _____ City _____ Zip _____

Father _____ Guardian
Name Place of Occupation Foster Parent Phone: _____
Step-Parent

Mother _____ Guardian
Name Place of Occupation Foster Parent Phone: _____
Step-Parent

HEALTH HISTORY	YEAR		YEAR	
Measles		Convulsions		Family Physician
3 Day Measles (Rubella)		Allergies, Hay Fever		
Scarlet Fever, Scarletina		Asthma		Phone #
Chicken Pox		Nose Bleeds		
Fifth Disease		Frequent Colds		<input type="checkbox"/> Glasses
Mumps		Frequent Sore Throat		<input type="checkbox"/> Contact Lenses
Heart Disease		Pneumonia		Eye Specialist
Diabetes		Ear Problems		
Epilepsy				Phone #

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
DPT					
Polio					
MMR					
Measles (9 day)					*As of February 22, 1999, Section 3313.671 of the Ohio Revised Code, the Compulsory Immunization Law, requires all Kindergarten students to receive the hepatitis B vaccine, evidence of having received two doses of MMR vaccine, a fifth dose of DTP/DtaP/DT/Td vaccine is required if the fourth dose was administered prior to the fourth birthday, a fourth dose of polio vaccine is required if the third dose was administered prior to the fourth birthday.
Rubella (3 day)					
Mumps					
HIB					
Chicken Pox					
Hepatitis B					
Other					
TD					
TB Test					
History of Accidents:					

PHYSICAL EXAMINATION: (To be filled in by your family doctor.)

Height _____ Weight _____ Nutrition _____ Skin _____ Eyes _____ Lungs _____ Ears _____
Nose _____ Abdomen _____ Throat _____ Nervous System _____ Genitalia _____
Teeth _____ Glands _____ Orthopedic _____ Hernia _____ Heart _____ Urine Test _____
Blood Pressure _____ Oral Hygiene _____

Is this student able to participate in the required physical education program? Yes _____ No _____

If not, what activities do you recommend? _____

Physician's Signature _____