

Corpus Christi School PHYSICAL EXAMINATION FORM

SECTION A: To be completed by parent before physical examination.

DATE: _____ SEX: M _____ F _____ GRADE: _____
 NAME: _____ BIRTHDATE: _____
 ILLNESS: Check and give dates of any that apply. HANDICAPS: Check and give details of any that apply.

ALLERGIES:				
ADD/ADHD		HEART TROUBLE		RHEUMATIC FEVER
ASTHMA		LYME DISEASE		SCARLET FEVER
CONSTIPATION		MENSTRUATION		SPEECH DIFFICULTY
DIABETES		MIGRAINE HEADACHES		STREP THROAT
EPILEPSY/SEIZURES		MONONUCLEOSIS		TUBERCULOSIS
FEQUENT EAR INFECTIONS		PHYSICAL HANDICAPS		URINARY DIFFICULTY
HEARING DIFFICULTY		PNEUMONIA		VISION DIFFICULTY

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include accident, surgeries, dates, etc): _____

SECTION B: To be completed by examining physician. Please indicate condition by code and give details.

CODE: X No Defect 1 defect, correction or care not necessary 2 defect, see remarks below
 B/P _____ HEIGHT _____ WEIGHT _____

NUTRITION		EARS		NECK		HERNIA	
SCALP/SKIN		NOSE		GLANDS		EXTREMITIES	
EYES		THROAT		HEART		NERVOUS SYSTEM	
DISTANT R20/		TEETH: temp		LUNGS		POSTURE	
DISTANT L20/		TEETH: perm		ABDOMEN		OTHER	

POSITIVE FINDINGS (include any additional pertinent history): _____

RECOMMENDATIONS (list any limitations of activity that the child should observe): _____

LIST DATES OF IMMUNIZATIONS RECEIVED:

DTP/DT1	DTP/DT2	DTP/DT3	DTP/DT4	DTP/DT5
OPV/IPV1	OPV/IPV2	OPV/IPV3	OPV/IPV4	
MMR1	MMR2	HEPB1	HEPB2	HEPB3
HIB1	HIB2	HIB3	HIB4	OTHER
Td1	VARICELLA-1	VARICELLA-2	LEAD LEVEL	

MANTOUX SKIN TEST DATE _____ RESULT _____
 TB RISK ASSESSMENT DATE _____ RESULT _____

 (Examiner's Signature)

 (Phone Number)