



SUSSEX CHRISTIAN SCHOOL

*Train up a child in the way he should go; and when he is old, he will not depart from it.
Proverbs 22:6*

STUDENT PHYSICAL EXAMINATION REPORT

Student's Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Home Phone #: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

Physician's Name: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Recent Immunizations: _____

Notes concerning child's pertinent past medical history: _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

Eyes: External: _____ Vision with glasses: R _____ L _____ Vision without glasses: R _____ L _____

Optic Fundi: _____ Heart: _____ Mouth: _____ Pharynx: _____

Ears: _____ Hearing: R _____ L _____ Nose: _____ Teeth: _____

Lungs: _____ Abdomen: _____ Skin: _____ Reflexes: _____

Genitalia: _____ Back: _____ Gross Motor Coordination: _____

General Condition: _____

PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD OR COMPLETE THE INFORMATION ON THE REVERSE SIDE OF THIS PAGE.

Physician's Signature: _____ Date: _____

STUDENT IMMUNIZATION RECORD

Student's Name: _____ Date of Birth: _____ Male Female

Parent's/Guardian's Name: _____

Address: _____

City, State, Zip: _____ Phone #: _____

Vaccine Type	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr
DTP or DTaP					
Td					
Polio					
Hib (specify type)					
MMR					
Measles					
Rubella					
Mumps					
Hepatitis B					
HBIG					
Varicella (specify) <input type="checkbox"/> Disease <input type="checkbox"/> Vaccine					
Pneumococcal Conjugate (PCV 7)					
Influenza					
Hepatitis B Serology	Date: _____		Titer: _____		
Varicella Serology	Date: _____		Titer: _____		

TUBERCULIN TESTS:

Date	Type/Lot #	Reaction

Disease History	Year	Disease History	Year	Disease History	Year	Operations or Injury	Year
Allergies		Asthma		Otitis Media			
Drug Sensitivities		Chicken Pox		Rheumatic Fever			
Lyme Disease		Convulsive Disorder		Strep Infections			
Hepatitis		Diabetes		Mononucleosis			
Neuromusc. Dis.		Heart Disease		Other			

Describe any medical contraindications: _____

Is there any reason why this child could not participate in our physical education program? ()Yes ()No
If "yes", please explain:

Are there any educational constraints or adjustments needed in the child's school program? ()Yes ()No
If "yes", please explain:

Physician's Signature: _____ Date: _____