SUSSEX CHRISTIAN SCHOOL

Challenging the Mind, Strengthening the Spirit

Student Physical Examination Form

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	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DTP or DTaP					
Td					
Polio					
Hib (specify type)					
MMR					
Measles					
Rubella					
Mumps					
Hepatitis B					
HBIG					
Varicella (specify) □Disease □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:**_____