Most Blessed Sacrament Catholic 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	
FREQUENT EAR INFECTIONS		PHYSICAL HANDICAPS		URINARY DIFFICULTY	
HEARING DIFFICULTY		PNEUMONIA		VISION DIFFICULTY	

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include accidents, 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		EXTREMETIES	
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)