CCHS ANNUAL SCHOOL/HEALTH EXAMINATION RECORD

NAME: _____ **D.O.B.:** _____ **SEX:** _____

ADDRESS: _____ **PHONE:** _____

PARENT/GUARDIAN: _____ **WORK PHONE:** _____

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	DATE
DPT						
TD						
POLIO						
MMR						
HIB						
HEPATITIS B						
TUBERCULIN TEST						
OTHER						

MEDICAL HISTORY:

Medications: ____None _____ Yes, please list: _____

Allergies: ____None _____ Yes, please list: _____

Chicken Pox: _____ yes _____ no _____ vaccination

Scoliosis: _____ yes _____ no _____ other: Describe
Plan of Care:

LABORATORY TESTS	DATE	RESULTS
UNINALYSIS		
LEAD TEST		
HEMATOCRIT		
OTHER		

PHYSICAL EXAMINATION

DATE	HEIGHT	WEIGHT	BP	VISUAL ACUITY	HEARING

Information for the school/camp nurse:

This patient has had a physical examination on the above date(s) and is fit for competitive sports and physical education. This patient has no restrictions unless listed below:

_____
Doctor's Signature

The parents, by their signature, deny any significant health problems have occurred since the above date. I see no reason why the above patient cannot participate in a full Camp/School/Day Care or interscholastic Athletic Program.

_____
Parent/Guardian Signature

THIS FORM IS VALID UP TO ONE YEAR FROM DATE OF PHYSICAL. PLEASE KEEP COPIES FOR FUTURE USE.