

IMMACULATE CONCEPTION SCHOOL
PHYSICAL FORM
Pre K through 3rd Grade

Name _____ Grade _____ Age _____

Part A. PHYSICAL FORM TO BE COMPLETED BY PHYSICIAN

HEIGHT _____	IMMUNIZATION DATES: include: month, day, year
WEIGHT _____	DPT/DT _____
B.P. _____	POLIO _____
PULSE _____	MMR _____ VARICELLA _____
URINALYSIS _____	MEASLES _____ HEP. B _____
HEARING _____	MUMPS _____ HIB _____
VISION _____	RUBELLA _____ PPD _____ RESULTS _____
LEAD _____	

Check Normal/Abnormal:

	N A		N A		N A		N A
NUTRITION	___ ___	HEART	___ ___	GENITALIA	___ ___	ORTHOPEDIC	___ ___
HEENT	___ ___	LUNGS	___ ___	HERNIA	___ ___	SKIN	___ ___
NECK	___ ___	ABDOMEN	___ ___	SCOLIOSOS	___ ___	NEURO	___ ___
OTHER	___ ___						

PHYSICIAN

- YES ___ 1. Is this student qualified for full physical activity, including co tact and non-contact sports? If NO please explain.

- NO ___ 2. In reviewing this student’s medical history, is there any physical factor, which might affect the student’s ability to learn?
 If YES, please explain. _____
- NO ___ 3. In this student’s developmental history, are there any factors that might be a problem in school?
 If YES, please explain. _____

ADDRESS

 PHYSICIAN’S NAME

 PHYSICIAN’S SIGNATURE

 DATE OF EXAM

CONTINUED ON BACK

Name _____

Grade _____

Part B. To be completed by Parents

Please answer the following questions. If you answered yes to any of the questions, please explain on the bottom of the form.

- | | Yes | No |
|--|-----|-----|
| 1. Does this student have asthma? | ___ | ___ |
| 2. Does this student have allergies to medicine, food or insects stings? | ___ | ___ |
| 3. Does the student take medication on a regular basis? | ___ | ___ |
| 4. Has the student ever has a serious illness or injury that caused loss of school for one week or more? | ___ | ___ |
| 5. Is the student missing a paired organ (kidney, eye, or testicle)? | ___ | ___ |
| 6. Has the student ever had a concussion or seizure? | ___ | ___ |
| 7. Does your child have (or ever had) diabetes, high blood pressure, frequent nose bleeds, bruises easily or unusual bleeding of any kind? | ___ | ___ |
| 8. Has the student been hospitalized for anything? | ___ | ___ |
| 9. Has the student experienced chest pain, unusual shortness of breath, dizziness, loss of consciousness, or palpitations with exercise? | ___ | ___ |
| 10. Have any member of this student's family, under the age of 50, had a heart attack, heart problem, or died unexpectedly? | ___ | ___ |
| 10. Does your child have any other physical or emotional condition(s) that you or your physician think we should know about? | ___ | ___ |

If you answered yes to any of the above, please explain.

Signature of Parent/ Guardian _____ **Date** _____