GRACE
COMMUNITY SCHOOL
Education that begins with the heart!

PHYSICIAN'S REPORT OF HEALTH EDUCATION

Please review the student's history and complete the physician's form. Please comment on all positive answers.

Student's Name _____ Male _____ Female _____
First **MI** **Last**

Birth Date ____/____/____ Weight _____ lb. Height _____ feet _____ inches

Medical History (age at onset)

_____	Asthma	_____	Heart Disease	_____	Pneumonia
_____	Chicken Pox	_____	Measles (type)	_____	Rheumatic Fever
_____	Convulsions	_____		_____	Scarlet Fever
_____	Diabetes	_____		_____	Whooping Cough
_____	Diptheria	_____	Mumps	_____	Other
_____	Discharging Ears	_____	Polio	_____	

Immunizations (enter dates given—month/day/year)

DtaP/DPT/DT/Td	1._____	2._____	3._____	4._____	5._____
Polio	1._____	2._____	3._____	4._____	
Haemophilus B (HIB)	1._____	2._____	3._____	4._____	
Hepatitis B 1	1._____	2._____	3._____		
MMR	1._____	2._____			
Varicella	1._____				
Other	1._____				

Physical Examinations:

_____	Eyes	_____	Chest	_____	Skin and Hair
_____	Heart	_____	Ears	_____	Abdomen
_____	Nose and Throat	_____	Genitalia	_____	Mouth and Teeth
_____	Hernia	_____	Coordination	_____	Skeletal

Recommendations for Physical Activities:

Do you have any recommendations for care of this student? _____

_____

Is student now under treatment for any medical or emotional disorder? If so, please specify: _____

_____

☐ Th s child has been examined and is in suitable condition to participate in group care.

Physician's Name (print or type) _____ Phone Number _____

Physician's Signature _____ Date _____

Physician's Address _____
Street City State Zip