ATTENTION: NURSE

Physician Certificate of Examination Form

(To be completed by a physician)

Please Print!

Name:_____ Date of Birth: ____/____/____

Allergies_____

Current Medications: (List name, dosage, and time)

1._____Dosage_____Time_____

2._____Dosage_____Time_____

Height:_____ Weight:_____ B/P:_____

Eyes: _____

Ears: _____ **Lead Level** (if indicated):_____

Nose: _____

Throat: _____ **Sickle Cell** (If indicated):_____

Chest: _____

Heart: _____ **P.P.D.: (Recommended)**

Hernia: _____ Date Given:_____

Extremities: _____ Date Read:_____

Posture/Scoliosis: _____ Results:_____

- Physically fit to participate in all physical education programs? Yes No
  If "No" please explain:_____
- Please list any condition that should be considered in planning this child's school day:_____

Please send in a copy of your Child's Immunization record from your Physicians office along with this document.

Christ the King

Fax: 574-273-6707

Physician completing this form: _____

Please Print/Stamp

Physician's Signature:_____Date_____