ATTENTION: SCHOOL 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:	______________________	Scoliosis:	______________________
Ears:	______________________	Lead Level:	______________________
Nose:	______________________	Sickle Cell:	______________________
Throat:	______________________	P.P.D.:	
Chest:	______________________	Date Given:	______________________
Heart:	______________________	Date Read:	______________________
Hernia:	______________________	Results:	______________________
Extremities:	______________________		

- ❖ 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 physician's office along with this document.

Christ the King School
Fax: (574)273-6707

Physician completing this form: ____

Please Print/Stamp

Physician's Signature: __________________________________ Date: ___/___/______