SACRED HEART CATHOLIC
PHYSICAL/IMMUNIZATION FORM

IDENTIFYING INFORMATION

Name of student _____ Date of birth _____

Grade_____ Exemptions Religious_____ or Medical _____

Parent or guardian_____ Address_____

Family Physicial_____ Family Dentist_____

VACCINE TYPE	Disease Date (Mo/Day/Yr)	DATES OF ADMINISTRATION (Mo/Day/Yr)					
DTaP/DTP/DT or Td (Specify)	XXXXXXX						
Polio – OPV –oral IPV – inactivated	XXXXXXX						
Measles	Dr Diagnosed						
Mumps	Dr Diagnosed						
Rubella	Laboratory Confirmed						
Hep A Hep B	----------						
Varicella (chickenpox)	Parental Report						
Tdap (Gr 6-12)							
MCV4 (Gr 6-12)							

PREVIOUS OR EXISTING DISEASES AND CONDITIONS

Allergies_____
Convulsions_____
Diabetes_____
Polio_____
Rheumatic fever_____
Other_____

FAMILY HISTORY OF TUBERCULOSIS, EPILEPSY AND DIABETES_____

MEDICAL EXAMINATION (leave blank if normal - X if abnormal)

General appearance _____ Nose and Throat_____ Blood Pressure_____
General nutrition _____ Mouth_____ Pulse_____
Posture_____ Teeth and gums_____ Abdomen_____
Height and Weight_____ Glands_____ Genitalia _____
Skin _____ Breasts _____ Bones and muscles _____
Scalp _____ Lungs _____ Nervous system_____
Eyes and lids _____ Heart _____ Emotional problems _____
Ears _____ Murmurs _____ Other _____

PHYSICIANS RECOMMENDATIONS		REMARKS
Is pupil physically capable of carrying a full program of school work?	Yes _____ No _____	_____
Should there be restrictions on up and down stair travel?	Yes _____ No _____	_____
Is special seating recommended?	Yes _____ No _____	_____
Does pupil have any uncorrectable defects?	Yes _____ No _____	_____
Is there evidence of emotional upset?	Yes _____ No _____	_____
Would a home visit by the nurse be desirable?	Yes _____ No _____	_____
Does pupil require continuing medical treatment?	Yes _____ No _____	_____

RECOMMENDATIONS TO SCHOOL ON MEDICAL FINDINGS

OTHER RECOMMENDATIONS (Indicate need for psychiatric, medical or surgical care)

CLASSIFICATION FOR PHYSICAL EDUCATION ACTIVITY		Remarks on Limitations
CODE	(Indicate code number on block)	
I	Unlimited activity	_____
II	Slightly modified-under observation	_____
III	Definitely restricted, i.e., cardiac, convalescent, etc.	_____
IV	Individual physical education	_____
V	Rest	_____

SIGNED _____ _____
Physician Date

OFFICE ADDRESS _____ _____
Street City Zip Tel. No.