Physician Certificate of Examination Form

(To be completed by a physician/healthcare provider)
Please Print!

◯ ***IMMUNIZATION DOCUMENTATION ATTACHED***

Name: ______________________________ Date of Birth: _____/_____/_____

Allergies: ___________________________ ◯ Epi Pen Needed

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: ______________________ TB Test: (Recommended)
Hernia: ______________________ Date Given: __________________
Extremities: __________________ Date Read: ___________________
Posture/Scoliosis: _______________ Results: ______________________

- Does this child have any health condition that would be hazardous either to the child or to the other children in the group setting as a result of participation in normal activities (including sports) ◯ YES ◯ NO
- If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates

  ____

Physician/Healthcare Provider Completing this Form: _________________________
Please Print/Stamp
Physician/Healthcare Provider's Signature: ______________________ Date: ________

Certificate of Dental Examination

Teeth:

1. Cavities: ____
2. Soft Tissue: ____
3. Oral Hygiene: ____

Present Status:

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
  - If yes, please explain: ______________________________________

Recommendations: ____
Dentist's Name (Stamp or Print): _______________________________________
Dentist's Signature: __________________________________ Date: ___________