NOTRE DAME CATHOLIC SCHOOL PHYSICAL FORM

(PLEASE PRINT)

Last Name ______________________ First ______________________ Middle Initial _____ Birthdate ______________

Address ______________________ City ______________________ Home Phone ______________

Parent/Guardian ______________________ Family Physician ______________________ Address ______________ Phone ______________

Gender _______ Medicine Taken Regularly ____

Please check (✓) if your child has had the following conditions:

1. Allergies ____ No ____ Yes to Medication ______________________ to Foods ______________ to Latex ________
2. Asthma ____ No ____ Yes Medication Name ______________________
3. Chicken Pox ____ No ____ Yes Disease Date ______________
4. Diabetes ____ No ____ Yes ______________
5. Ear Infections ____ No ____ Yes ______________
6. Ear Tubes ____ No ____ Yes Date ______________ Still in Place? ______________ R______ L______ Both ________
7. Pneumonia ____ No ____ Yes Date ______________ Hospitalized ____________
8. Tonsillitis ____ No ____ Yes ______________________
9. Eczema ____ No ____ Yes ______________________

List any chronic conditions: ____

Parent Signature ______________________ Conditions which could affect school activities ______________________

PARENTS: PLEASE COMPLETE THE ABOVE AREA BEFORE TAKING TO THE DOCTOR'S OFFICE.

Completed by Physician:

Height (inches) _________ Weight (lbs.) ________ * Lead Level ______________ Date _________ (Does not need to be current)

General Appearance _____ Healthy _____ Poor ______________ Posture _____ Normal _____ Other ______________

Nutrition _____ Good _____ Fair _____ Poor ______________ Nose & Throat _____ Normal _____ Other ______________

Eyes & Ears _____ Normal _____ Other ______________ Tonsils & Glands _____ Normal _____ Other ______________

Heart & Lungs _____ Normal _____ Other ______________ Abdomen _____ Normal _____ Other ______________

Pertinent Family History ____

Chronic Disease Notes ____

Operations or injuries ____

EXAMINED BY: ______________________ **PRINTED NAME** ______________________ **DATE** ____________

(Signature)

*REQUIRED