GRACE COMMUNITY SCHOOL
Education that begins with the heart!

PHYSICIAN'S REPORT OF HEALTH EDUCATION

Please review the student's history and complete the physician's form. Please comment on all positive answers.

Student's Name _____ Male _____ Female _____
First **MI** **Last**

Birth Date ____/____/____ Weight _____ lb. Height _____ feet _____ inches

Medical History (age at onset)

_____ Asthma	_____ Heart Disease	_____ Pneumonia
_____ Chicken Pox	_____ Measles (type)	_____ Rheumatic Fever
_____ Convulsions	_____	_____ Scarlet Fever
_____ Diabetes	_____	_____ Whooping Cough
_____ Diptheria	_____ Mumps	_____ Other
_____ Discharging Ears	_____ Polio	_____

Immunizations (enter dates given—month/day/year)

DtaP/DPT/DT/Td	1._____	2. _____	3. _____	4. _____ 5._____
Polio	1._____	2. _____	3. _____	4. _____
Haemophilus B (HIB)	1._____	2. _____	3. _____	4. _____
Hepatitis B 1	1._____	2. _____	3. _____	
MMR	1._____	2. _____		
Varicella	1._____			
Other	1._____			

Physical Examinations:

_____ Eyes	_____ Chest	_____ Skin and Hair
_____ Heart	_____ Ears	_____ Abdomen
_____ Nose and Throat	_____ Genitalia	_____ Mouth and Teeth
_____ Hernia	_____ Coordination	_____ Skeletal

Recommendations for Physical Activities:

Do you have any recommendations for care of this student? _____

_____

Is student now under treatment for any medical or emotional disorder? If so, please specify: _____

_____

☐ This child has been examined and is in suitable condition to participate in group care.

Physician's Name (print or type) _____ Phone Number _____

Physician's Signature _____ Date _____

Physician's Address _____
Street City State Zip