CHARLES A. BEARD MEMORIAL SCHOOL CORP. PHYSICAL RECORD

NOTE: This form MUST be returned to the School Office before the child will be admitted to the *first day of school*

(PLEASE PRINT)

STUDENT'S NAME:____
Last First Middle

PARENT/GUARDIAN:____________________________PHONE #____________

BIRTH DATE:__________________________SEX: MALE______FEMALE_____
Month-Day-Year

MEDICATIONS TAKEN REGULARLY (Please list milligram and how many taken daily)

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____

SPECIAL HEALTH PROBLEMS AND ALLERGIES (List)__________________

____

____

MEDICAL HISTORY: (List Dates)

Rheumatic Fever ______________ Chicken Pox ______________ Diabetes________

Measles (Rubeola 10-day)_______ Rubella(3-day Measles)______ Mumps ________

Hemophilia________________ Tuberculosis______________ Epilepsy________

Seizures____________________ Bee Sting Allergy___________ Asthma________

Hay Fever __________________ Other Allergies:_____________________________

Other Medical Conerns____

Health Problems, Surgery or Permanent Injury___________________________

Behavioral Habit____

MEDICAL EXAMINATION: B/P____________ Height__________ Weight__________

Pulse____________ Urinalysis_________________ VISION R ____________ L _________________

Skin/Scalp________Ears R ________ L _________ Nose/Throat /Tonsils ___________________

Dental __________Cardiovascular______________ Respiratory __________Neurological________

Gastrointestinal ______________Genito/Urinary____________Muscular Skeletal____________

Scoliosis Screening____________Nutritional Status___________Speech_________Hearing_______

THE FOLLOWING TESTS ARE NOT REQUIRED:

Sickle Cell Anemia Test Yes__________ No__________ Date __________Results____________

Tuberculin Skin Test Date__________ Results______ Date__________Results____________

TUBERCULOSIS SKIN TEST IS HIGHLY RECOMMENDED WHEN RECEIVING THE KINDERGARTEN PHYSICAL

OTHER VACCINE OR TEST Date________ Results_________

May this child take part in playground and gym activities? ______________________________

Does this child have any limitations or restrictions? ___________________________________

Any Additional Comments or Recommendations? ________________________________

Physician Signature: ___________________________Printed Name:_______________M.D. Phone____________

Signature of Parent or Guardian:____Date:________________