CROWN POINT COMMUNITY SCHOOL CORPORATION

Important Information to PARENTS:
The Crown Point Community School Corporation requires all students in 6th and 9th grades to be examined by a physician. The information requested on these forms will be of help to the school authorities in determining the health status of your child and in assisting him to receive maximum benefits from his educational experience.

Please complete this side of the card, the reverse side is to be completed by the doctor.

Instruct your child to return the card to his homeroom teacher or school nurse on the first day of school.

9th grade summer school students must return the completed card to the PE teacher on the first day of summer school.

Name of Student _____

Address _____

Has your child had any of the following: (Give details)

Allergy _____

Recurring Illness _____

Operations (note type) _____

Serious Accidents _____

Epilepsy _____

Diabetes _____

Other _____

If the need arises and it is not possible or practical to contact me, I authorize a Crown Point representative to contact

Dr. _____

or any licensed physician. I further authorize any medical treatment, including hospitalization, that is medically indicated. Payment is the responsibility of the parent.

I give the school nurse permission to discuss my child's health condition(s) with school personnel who have a need to know in order to meet the health and safety needs of my child.

_____ _____

Date Signature of Parent or Guardian

STUDENT: Take a urine specimen with you to the doctor.

Height _____ Heart _____

Weight _____ Lungs _____

B/P _____ Abdomen _____

Eyes _____ Throat, glands _____

Ears _____ Others _____

Scoliosis pos. ____ neg. ____ T_X _____ Urinalysis: Sp. gr. _____ S&A _____

Does this student take medication? _____ If so, why? _____

Should physical education activities be restricted? _____

(A form listing all PE activities is available from the School Nurse)

Are Immunization Boosters needed? (Type & Date given) _____

Comments or Recommendations: _____

_____

_____ _____ D.O./M.D.

Date Physician's Signature

The payment of this examination is the responsibility of the parent.