VALLEY CHRISTIAN ELEMENTARY

The Road to Excellence

HEALTH EXAM FORM

This form **MUST BE COMPLETED AND RETURNED** before the child begins school. A physical is required within one year prior to starting our school.

To be filled in by parent or guardian before the time of the examination. (Please print plainly with ink.)

Pupil's Name:_____ Birth:_____ Sex: M_____ F_____
Last First

Address _____ Phone ( )_____
Street City Zip

Student's Physician _____ Phone ( )_____
Last First

Birth, infancy and preschool history: Record unusual problems, complication during pregnancy, e.g. hard labor, febrile episodes, convulsions, accident, operation, exposure to TB, behavior difficulties, problems of sleep and rest; poison injection, etc.

_____

_____

Development	Age	Development	Age
Walked alone	_____	Bowel control	_____
Talked words	_____	Bladder control	_____
Sentences	_____	Dressed self	_____

Past history of illnesses, state the month and year in which the child had any of the following.

Communicable Diseases		Other Diseases		Other Conditions
Chicken Pox	_____/_____	Asthma	_____/_____	Constant cough_____
Diphtheria	_____/_____	Diabetes	_____/_____	Fainting spells_____
German measles	_____/_____	Hay fever	_____/_____	Frequent colds_____
Poliomyelitis	_____/_____	Kidney trouble	_____/_____	Frequent sore throats_____
Scarlet fever	_____/_____			Frequent urination_____
Whooping cough	_____/_____	Pneumonia	_____/_____	Hearing difficulty_____
Mumps	_____/_____	Rheumatic fever	_____/_____	Tires easily_____
				Vision difficulty_____
		Tonsillitis	_____/_____	Frequent headaches_____
				Frequent stomach aches_____
				Frequent ear infections_____

Other information of value to the teacher, e.g. current medication or therapy.

_____

_____

_____

Allergies (list) be sure to Include "bee sting" allergy.

_____

_____

Attention Deficit Disorder

_____

_____

Glasses: _____Yes _____ No

IMMUNIZATION EXEMPTION FOR PERSONAL BELIEFS:

I hereby request exemption of my child, named above, from the immunization requirements for school entry because these immunizations are contrary to my beliefs.

_____ _____
Signature of Parent or Guardian Date

PHYSICAL

TO BE COMPLETED BY PHYSICIAN Pupil's Name_____

Parent(s) present: Yes_____ No_____

Vision: without glasses: right eye 20/_____ left eye 20/_____
with glasses: right eye 20/_____ left eye 20/_____
color vision:_____ test used:_____

Hearing: right ear:_____ left ear:_____

Eyes	_____ Normal	_____ Defect	_____
Ears	_____ Normal	_____ Defect	_____
Nose	_____ Normal	_____ Defect	_____
Throat	_____ Normal	_____ Defect	_____
Lymph Nodes	_____ Normal	_____ Defect	_____
Heart	_____ Normal	_____ Defect	_____
Lungs	_____ Normal	_____ Defect	_____
Abdomen	_____ Normal	_____ Defect	_____
Blood Pressure	_____ Systolic	_____ Diastolic	_____
Genitals	_____ Normal	_____ Defect	_____
Posture	_____ Normal	_____ Defect	_____
Extremities	_____ Normal	_____ Defect	_____
Nervous System	_____ Normal	_____ Defect	_____
Skin	_____ Normal	_____ Defect	_____
Nutrition	_____ Normal	_____ Defect	_____
Musculature	_____ Normal	_____ Defect	_____
Emotional	_____ Normal	_____ Defect	_____
Other:			
_____	_____ Normal	_____ Defect	_____
_____	_____ Normal	_____ Defect	_____

Hemoglobin_____
Urinalysis_____
Findings and recommendations_____
_____
_____

Immediate medical referral: Yes_____ No_____ Dental referral: Yes_____ No_____

Unlimited activity_____ Limited activity_____

IMMUNIZATIONS

Along with this health form, please present your child's personal immunization record. In most cases, it will be a yellow California Immunization Record or similar form given to the parent by the doctor or clinic, which shows the date each required vaccine dose was received. Please examine the card before submitting it to make sure dates are correct and that these dates can easily be read. For students entering Kindergarten, these dates will be transcribed onto the blue California School Immunization Record, which will become part of the child's mandatory cumulative folder.

_____M.D. _____
Examining Physician Date of Examination