



Child Physical Health Examination

I allow my physician to release information about my child's health to Friends School and Day Care.
 Parent Signature: _____

Fax (574) 271-1885

Patient Information

Name (Last, First, Middle Initial)	Date of Birth	Date of Exam
Address (City, State, Zip)		
Child Lives With:	Name:	Phone:

Medical History

Communicable Disease	Month/Year	Condition	Explain if present:
Measles	_____	Allergies	_____
Rubella (German measles)	_____		_____
Chicken Pox (Varicella)	_____	Physical Limitations	_____
Mumps	_____		_____
Scarlet Fever	_____	Other:	_____
Whooping cough	_____		_____
Hepatitis B	_____		_____
Other:	_____		_____

Physical Examination

Date of Exam: _____		Age of Child _____	
Skin	_____	Abdomen	_____
Lymph Nodes	_____	Genitalia	_____
Eyes	_____	Skeleton	_____
Ears	_____	Heart	_____
Nasopharynx	_____	Lungs	_____
Teeth & Mouth	_____	Other	_____

Note any unusual findings: _____

Does this child have any health condition that would be hazardous to him/herself or to other children in a group setting as a result of normal activities (including sports)? Yes _____ No _____ If "YES" what modification of normal activities would be necessary to protect the child and his/her classmates?

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Yes _____ No _____ If "YES" please explain: _____

Immunization History

DtaP/DT/Td/TD	OPV, IPV	Hib	Hepatitis B	Measles	Mumps	Rubella	Varicella	PCV7	Hep A

Physician's Name (Please Print): Phone Number:	Physician's Signature:
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