ST. ALOYSIUS SCHOOL PHYSICAL EXAMINATION REPORT

627 Beatrice Drive, Tulare, CA 93274
School Office Phone 559.686.6250 Fax 559.686.0479

STUDENT'S NAME _____ _____ _____ Date of Birth ___/___/___
Student's Legal Last Name *Full First Name* *Middle Name* *month/day/year*

Address _____ Gender Male ❑ Female ❑
Street *City* *State* *Zip*

Home Phone_____ School _____

HISTORY

Have you had any unusual medical problems, serious illness, accidents, or surgery? ❑ Yes ❑ No

Comments _____

IMMUNIZATIONS AND TESTS (Please state month/day/year)

STATE MANDATED	1	2	3	Booster 1	Booster 2
Polio					
DPT					
MMR					
HIB Meningitis					
Hepatitis B					
Varicella (chicken pox)					
	DATE	**RESULTS**	**DATE**	**RESULTS**	
Tuberculin Test (PPD)					

PARENT'S AUTHORIZATION

I hereby give my consent to St. Aloysius School to receive from or send to Dr. _____ any information concerning my child's health.

_____ _____
Signature of Parent or Guardian *Date*

PHYSICAL EXAMINATION (To be completed by physician)

Date of Examination _____ Age _____ Height _____ Weight _____ B/P _____

Normal	Clinical Evaluation	Abnormal	Comment
	Skin		
	Eyes (general)		
	Eyes (vision)		
	Ears (general)		
	Ears (hearing)		
	Nose, throat, neck		
	Teeth		
	Heart and lungs		
	Abdomen		
	Genitals, hernia		
	Extremities, back reflexes		

Urine: Albumin _____ Sugar _____ Hemoglobin _____

Is there any reason this child should have restricted P.E.? _____

Is this child on any medication? _____

_____ _____
Physician's Signature *Date*