# 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*