

Physician Certificate of Examination Form

(To be completed by a physician/healthcare provider)

Please Print!

IMMUNIZATION DOCUMENTATION ATTACHED

Name: _____ Date of Birth: ____/____/____

Allergies: _____ Epi Pen Needed

Current Medications: (List name, dosage, and time):

1. _____ Dosage: _____ Time: _____

2. _____ Dosage: _____ Time: _____

Height: _____ Weight: _____ B/P: _____

Eyes: _____

Ears: _____ Lead Level (if indicated): _____

Nose: _____

Throat: _____ Sickle Cell (If indicated): _____

Chest: _____

Heart: _____ TB Test: (Recommended)

Hernia: _____ Date Given: _____

Extremities: _____ Date Read: _____

Posture/Scoliosis: _____ Results: _____

- Does this child have any health condition that would be hazardous either to the child or to the other children in the group setting as a result of participation in normal activities (including sports) YES NO
- If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates

Physician/Healthcare Provider Completing this Form: _____

Please Print/Stamp

Physician/Healthcare Provider's Signature: _____ Date: _____

Certificate of Dental Examination

Teeth:

1. Cavities: _____

2. Soft Tissue: _____

3. Oral Hygiene: _____

Present Status:

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
 - If yes, please explain: _____

Recommendations: _____

Dentist's Name (Stamp or Print): _____

Dentist's Signature: _____ Date: _____