



**HERITAGE
SCHOOL**

**2017-2018
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION**

DATE _____

Please Return to:
THE HERITAGE SCHOOL
651 NORTH WAYNE AVE.
WAYNE, PA 19087
FAX: 610-989-0591
Email: heritage@cosnet.org

Name of Child _____

Date of Birth _____

Address _____

Height _____ Weight _____ Sex _____

MEDICAL HISTORY

Give significant details, including serious illnesses, allergies, operations, accidents, etc. **A separate Emergency Action Plan form must be filled out for children with severe allergies.**

Has child had: Chicken pox ____ Date _____

Measles ____ Date _____

German Measles ____ Date _____

Have immunizations required by law been administered? YES _____ NO _____

Please attach a copy of the immunization record

PHYSICIAN'S REPORT OF EXAMINATION

General Health Status: Good _____ Poor _____

Vision Right 20/ _____ Vision Left 20/ _____

Wears corrective lens? YES _____ NO _____

Does this patient have any mental impairment? YES _____ NO _____

If yes, are they under treatment? YES _____ NO _____

Should child have restrictions on play or physical education activities? YES _____ NO _____

If yes, what should these restrictions be?

Additional comments: (PLEASE USE THIS SPACE TO INDICATE ANYTHING THAT YOU THINK IS IMPORTANT FOR US TO KNOW AND WAS NOT COVERED ELSEWHERE)

Signature of examining physician

Date

Name, address, and telephone number of physician: (PLEASE PRINT)

A COPY OF THIS CHILD'S RECORD OF IMMUNIZATIONS MUST BE ATTACHED TO THIS EXAMINATION FORM. THANK YOU!