2018-2019 SCHOOL YEAR
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

HERITAGE SCHOOL

DATE_____

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

Name of Child_____ Date of Birth_____ Sex_____

Address_____

MEDICAL HISTORY -- Give significant details, including serious illnesses, allergies, operations, accidents, etc.
A separate <u>Emergency Action Plan</u> form must be filled out for children with severe allergies.

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Have immunizations required by law been administered? YES_____ NO_____

<u>Please attach a copy of the immunization record and health summary from the doctor's office</u>

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?

_____

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_____ _____
Signature of examining physician Date

<u>Name, address, and telephone number of physician: (PLEASE PRINT)</u>

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<u>A RECORD OF IMMUNIZATIONS MUST BE ATTACHED TO THIS EXAMINATION FORM. THANK YOU!</u>