



ST. TIMOTHY'S SCHOOL

2004 NATIONAL BLUE RIBBON SCHOOL

Physical form

Below completed by Parent or Guardian.

Child's Name _____ Today's Date _____

Date of Birth _____ Age _____ Sex _____ **Grade entering** _____

Address _____ City / Zip _____

Home Phone _____ Cell Phone _____

List any problems that might affect your child's performance in school.

Does your child take any medication routinely?

All children entering St. Timothy's for the first time must have a current physical (performed during this calendar year) on file by **July 15** or within 30 days of a late admission.

Signature of Parent/Guardian

Date

Health assessment (To be completed by Child's Physician)

*****Date Health Assessment Completed** _____

Please check all lines that are applicable.

_____ No concerns, special needs or recommendations noted at this assessment.

Please list any allergies that the child has (food, insect, medicine, etc.) _____

What type of reaction occurs? _____

Response required: Epinephrine Auto-inject _____ Other: _____ None: _____

Does this child require a special diet? ___ Yes ___ Specify modifications: _____

Does this child take medication (prescription or O.T.C) on a routine basis? List medications: _____

Does **any** Medication need to be given at school? ___ Yes ___ No.

List any medical, dental, developmental conditions, and/or disabilities which this child has and the extent to which these conditions might affect performance in school. _____

Has this child had any hospitalizations? ___ Yes ___ No. If yes, please indicate when and for what. _____

Is this child approved to participate in all sports activities? ___ Yes ___ No

Please explain if answer is no. _____

Health Forms Attached: ___ Diabetes Care Plan ___ Asthma Action Plan

___ Health Care Plan (List Condition) _____

IMMUNIZATIONS - ATTACH A COPY OF COMPLETED IMMUNIZATION RECORD TO THIS FORM

Continued on back

Name: _____ D.O.B _____

TESTING

Hct or Hgb _____ Chol _____ Urine _____
Vision Screening – Test Used _____ Results R _____ L _____
Wearing Glasses: Yes _____ No _____
Stereopsis Exam Pass _____ Fail _____
Hearing Test – Normal range - Yes _____ No _____ Referral date _____
Hearing Aids: Yes _____ No _____
Developmental Evaluation – Test Used _____
Within Normal Limits _____ Needs Follow-up _____ Referral date _____

Physical Exam

Height _____ Weight _____ BP _____

(O – Normal, X – Abnormal. Please elaborate for any abnormal results).

Skin /Nodes _____ Chest/Lungs _____ Muscular/ Skeletal _____
Head/Neck _____ Heart/Circulation _____ Neurological _____
E.E.N.T. _____ Genital/ Urinary _____ Abdomen _____

Abnormal results: _____

Please check any of the following illnesses or behavioral difficulties the child has or has had:

- | | | |
|----------------------------|----------------------------|-------------------------|
| _____ Asthma | _____ Attention/Learning | _____ Bleeding Problems |
| _____ Bowel Problems | _____ Convulsions/ Seizure | _____ Cystic Fibrosis |
| _____ Cerebral Palsy | _____ Dental Problems | _____ Speech Problems |
| _____ Diabetes | _____ Ear Infections | _____ Heart Problems |
| _____ Cancer/Leukemia | _____ Hearing Problems | _____ Meningitis |
| _____ Sickle Cell Anemia | _____ Skin Problems | _____ ADD/ADHD |
| _____ Digestive/ Stomach | _____ Bone/ Muscle | _____ Urinary/Bladder |
| _____ Emotional/Behavioral | | _____ Other |

For any checked above, please provide additional information below.

List any other health considerations or referrals needed for this child while in school. _____

Signature of Physician _____ **Date** _____

Print or stamp Physicians name, address and phone number below.