Gifft Hill School

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STUDENT PHYSICAL

*** Please return this form WITH the immunization records ***

Adapted from VI Department of Human Services

*** SECTION I – TO BE COMPLETED BY PARENT(S) ***		
Child's Name: (Last) (First)	Date of Birth / /	Sex
Parent(s) / Guardian(s) Name(s)	Home / Work Phone ( )	Cell Phone ( )
I give my consent for my child's Health Care Provider to share the information on this form.	**Primary Health Care Service Provider:** *(Name, Phone # of Physician, Clinic, Hospital)*	
Signature / Date		

*** SECTION II – TO BE COMPLETED BY HEALTH CARE PROVIDER ***		
Date of Physical Examination:	Results of physical exam normal? ( ) Yes ( ) No	
*** General Appearance (Note Abnormalities of the following, if any) *** *Nutrition, Nose, Lungs, Malformation, Head, Throat, Abdomen, Chest, Eyes, Heart, Genitalia, Tonsils, Ears, Adenoids, Skin, Teeth*	Weight / Height	Blood Pressure

Preventive Health Screenings

Type Screening	Date Performed	Note if Abnormal	Type Screen	Date Performed	Note if Abnormal
Hearing			Sickle Cell		
Vision			Stool		
Dental			Urinalysis		
Development			Lead: ( ) Capillary ( ) Venous		
Hematocrit / Hemoglobin			Last Dentist's Exam		

***** Immunizations ***** ( ) Immunization Record Attached ( ) Date Next Immunization Due:

Polio/IPV _____ _____ _____
DTAP _____ _____ _____ _____ _____
MMR _____ _____
BCG _____
PPD _____
HIB _____ _____ _____ _____
Hepatitis B _____ _____ _____
HBIG _____
Varicella _____
PCV 7 _____ _____ _____ _____
FLU _____ _____ _____ _____
Other: _____

History of Diseases

( ) Mumps
( ) Measles
( ) Polio
( ) Whooping Cough
( ) Chicken Pox
( ) Other disease and illness _____
_____
_____

Family History of Disease

Parasites ( ) Yes ( ) No
Tuberculosis ( ) Yes ( ) No
Diabetes ( ) Yes ( ) No
Others: _____
_____
Explain: (if yes to any): _____
_____
_____

Medical Conditions ( ) Special Care Plan Attached

Chronic Medical Conditions
( ) None
Medications / Treatments
( ) None
Limitations to Physical Activity
( ) None
Special Diet / Vitamin & Mineral Supplements
( ) None
Behavioral Issues / Mental Health Diagnosis
( ) None
Emergency Plans
( ) None

History of Allergies / Sensitivities

_____ _____ _____ _____
_____ _____ _____ _____

**** I have found this child free of communicable and contagious diseases and up to date on immunizations. ****

( ) Yes ( ) No

Physician's Signature _____ Date _____

Next Appointment: _____

Health Care Provider Stamp: