

ASOCIACIÓN ADVENTISTA DEL ESTE
CORPORACIÓN EDUCATIVA
ACADEMIAS ADVENTISTAS DEL ESTE
 PO BOX 29027
 SAN JUAN, PR 00929-0027



NAME _____ GRADE _____ AGE _____ BIRTH _____

I. List all childhood diseases, allergies, operations, and other illness:

1. _____ 2. _____
 3. _____ 4. _____

II. List any all restrictions or conditions affecting schoolwork:

1. Important medications child is on: _____
 2. Important medication that should be at school with child for his or her particular allergy, convulsion, etc.
 3. Wear glasses, braces etc. _____

III. Immunization records please include P-VAC-3:

IV. PHYSICAL EXAMINATION			
HEIGHT		WEIGHT	
GENERAL APPERANCE		CHEST AND LUNGS	
EYES		HEART	
VISION WITH GLASSES		ABDOMEN, HERNIA	
R		GENITALS	
L		EXTREMITIES	
COLOR VISION		SKIN	
HEARING		POSTURE, GAIT, SPINE	
R		COORDINATION	
L		BLOOD PRESURE	
TEETH AND GUMS		NEUROLOGICAL	
NUTRITION		PHYSICAL AND EMOTIONAL HANDICAPS	
SCALP, HEAD, NECK		OTHER	
EARS			
NOSE			

V. Diagnostic and Recommendations: _____

VI. Recommended activity for physical education and athletics: Full _____ Limited _____

Explain: _____

Physician _____
 Print Sign License #

Date _____