PHYSICAL FORM

Child LAST NAME: _____ FIRST NAME: _____ M.I. _____

Gender: [ ] MALE [ ] FEMALE DATE OF BIRTH: _____ NATIONALITY: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____

DRUG, FOOD, OTHER ALLERIGES:

_____

_____

_____

IS THE CHILD CURRENTLY TAKING ANY PERSCRIBED MEDICATION [ ] YES [ ] NO

IF YES, LIST MEDICATION, DOSAGE, AND REASON

MEDICATION: _____ DOSAGE: _____ REASON: _____
MEDICATION: _____ DOSAGE: _____ REASON: _____

PLEASE NOTE ANY HEALTH PROBLEMS, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL

DESCRIBE:

_____

_____

_____

IS CHILD SUBJECT TO ANY LIMITS FOR CLASS ACTIVITES AND PHYSICAL EDUCATION?

[ ] YES [ ] NO

IF YES, DESCRIBE:

_____

_____

_____

ADDITIONAL REMARKS OR SUGGESTIONS:

_____

_____

BASED ON MY ASSESSMENT OF THIS CHILD'S MEDICAL HISTORY, CURRENT STATE OF HEALTH AND MY PHYSICAL EXAMINATION, _____,
CHILD NAME

[ ] **MAY** PARTICIPATE IN CHILD CARE PROGRAM ACTIVITIES WITHOUT RESTRICTION.

[ ] **MAY <u>NOT</u>** PARTICIPATE IN CHILD CARE PROGRAM ACTIVITIES WITHOUT RESTRICTION.

_____
MEDICAL FACILITY/CLINIC

_____ _____ _____
NAME OF PHYSICIAN/PRACTITIONER SIGNATURE DATE