ST. TIMOTHY'S SCHOOL
Life-Ready.

Comprehensive Physical Form

This form is used for 6th graders and all newly enrolled students.

To be 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 _____ Email _____
List any problems that might affect your child's performance in school.

_____
Does your child take any medication routinely?

_____

All children in 6th grade and at the time of admission must present a current physical (completed in the last 365 days) and a complete immunization record (signed by the physician).

_____ _____
Signature of Parent/Guardian **Date**

Health Assessment (to be completed by *Child's Physician)*

Date 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** Attach a medication release form for that medication.
Does this child have any medical, dental, developmental conditions and/or disabilities that might affect their performance at school? **Yes No** If yes, please list:

_____
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._____

Forms Attached: (circle any that apply)

Diabetes Care Plan Asthma Action Plan Health Care Plan (list condition)_____

Name _____ D.O.B. _____

Immunizations: Attach a copy of completed Immunization Record to this form. Immunization record must include physician signature.

Testing (please list findings if part of today's physical exam)

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

Physical Exam

Height _____ Weight _____ BP _____ P _____ R _____ BMI _____
(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	☐ Enuresis (nighttime)
☐ Encopresis	☐ Heart Problems	☐ Enuresis (daytime)
☐ Cancer/Leukemia	☐ Hearing Problems	☐ Meningitis
☐ Sickle Cell Anemia	☐ Skin Problems	☐ ADHD
☐ Digestive/Stomach	☐ Bone/Muscle	☐ Urinary/Bladder
☐ Emotional	☐ Behavioral	☐ Other

Please provide additional information below on any area checked:

_____

_____

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

_____

Physician signature _____ **Date of exam** _____

Print or stamp Physician's name, address and phone number in box.

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