Physician Certificate of Examination Form

(To be completed by a physician/healthcare provider)
Please Print!

◯ ***IMMUNIZATION DOCUMENTATION ATTACHED***

Name: _____ Date of Birth: _____/_____/_____

Allergies: _____ ◯ Epi Pen Needed

Current Medications: (List name, dosage, and time):

1. _____ Dosage: _____ Time: _____
2. _____ Dosage: _____ Time: _____

Height: _____ Weight: _____ B/P: _____
Eyes: _____
Ears: _____ Lead Level (if indicated): _____
Nose: _____
Throat: _____ Sickle Cell (If indicated): _____
Chest: _____
Heart: _____ TB Test: (Recommended)
Hernia: _____ Date Given: _____
Extremities: _____ Date Read: _____
Posture/Scoliosis: _____ Results: _____

- Does this child have any health condition that would be hazardous either to the child or to the other children in the group setting as a result of participation in normal activities (including sports) ◯ YES ◯ NO
- If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates

  _____

Physician/Healthcare Provider Completing this Form: _____
Please Print/Stamp
Physician/Healthcare Provider's Signature: _____ Date: _____

Certificate of Dental Examination

Teeth:

1. Cavities: _____
2. Soft Tissue: _____
3. Oral Hygiene: _____

Present Status:

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
  - If yes, please explain: _____

Recommendations: _____
Dentist's Name (Stamp or Print): _____
Dentist's Signature: _____ Date: _____