## Certificate of Child Health Examination—*Protestant Reformed Christian School*

## For K entry and all new students, 2024/2025 10790 Calumet Ave. Dyer, IN 46311

Name of Studen	:				Μ	F	Gra	de:	Date of Birth:	
	Last	Fir	st							
Parent Names:			Address: _							
Home Phone: _			Cell Phone:							
Alternate Contac	Alternate Phone:									
Hoolth History	. Doos the shil	d have special k	acalth concorns	modica	ation	or f	ood a	lorgios or	a condition requiring the need for medication	
to be taken at s		•	lealth concerns,	ineuica	atioi	1 01 1	oou a	liergies, or	a condition requiring the need for medication	
Asthma Epile	psy Diabetes	Tuberculosis	S Chronic Ear	Infection	ons	ΑĽ	DHD	Murmur	Other (Please describe or list medications):	
Has the child be	en tested for?	Hearing: Y	N Vision	n: Y	N				*B :- 1- 1/ 1 1 1	
Does the child v	vear glasses/cor	ntacts? Y N	Recent ey	e exam	n:				*Prior to K entry, and for all new	
Has your child h	ad: (please give	e month and ye	ar of occurrence	e)					students it is highly recommended for students to have a vision	
Measles	Mump	sR	ubella	Pe	ertus	sis _		<del></del> -	screening completed. Please have a	
<u>Immunization</u>	History (give	month/date/ ye	ar) * = required fo	or all grad	des, u	ınless	otherv	vise noted	healthcare provider sign, and provide results as either PASS/FAIL*	
DPT (or DTaP, DT, Td)	*	*	*	*			*		results as either PASS/TAIL	
Polio (OPV or IPV)	*	*	*	*					Signature	
Нер В	*	*	*						Vision screen result/Referral to Ophthalmologist YES OR NO	
Varicella	*	*	IF the students <b>HAD</b> chicken pox disease, please complete the box to the RIGHT					For all new students & those entering <b>K</b> who have		
MMR	*	*	Hep A (2 doses required for ALL grades)	*			*		had chicken pox (varicella), a <i>healthcare provider</i> signature and date of the occurrence is required.	
Below for students			,	ı						
MCV4	*(due gr 6-11)	*(2 <sup>nd</sup> due gr 12)							Provider signature	
(Meningococcal) Tdap	*(due gr 6-11)		J							
Таар									Month/year	

## **Physical Examination**

Student Name:		Heigl	ht:	Weight:						
Systems:	Findings:	Systems:	:	Findings:						
General		Neurologic								
Skin/Hair		Endocrine								
HEENT		Extremities								
Cardiac		Postural Scree	ening							
Respiratory		*Referral?								
GI/GU		Other								
_										
Recommendations for cor	rection or follow-up:									
On the basis of today's ex	camination,									
I approve this child to take part in playground and gym activities. Y N										
I approve this chil	d to participate in interscholasti	ic sports.	Y N							
Restrictions:										
Physician Name:		Signature:		Date:						