Certificate of Child Health Examination—

Protestant Reformed Christian School and Heritage Christian High School

For returning students, entering grades 1-12 2024/2025

10790 Calumet Ave. Dyer, IN 46311

Name of Student: _____ Sex: M F Grade: _____ Date of Birth: _____
Last First

Parent Names: _____ Address:_____

Home Phone: _____ Cell Phone: _____

Alternate Contact: _____ Alternate Phone: _____

Health History: Does the child have special health concerns, medication or food allergies, or a condition requiring the need for medication to be taken at school? Such as:

Asthma Epilepsy Diabetes Tuberculosis Chronic Ear Infections ADHD Murmur Other (Please describe or list medications):

_____

Has the child been tested for? Hearing: Y N Vision: Y N

Does your child wear glasses/contacts? Y N Recent eye exam? _____

Has the child had: (please give month and year of occurrence)

Measles _____ Mumps _____ Rubella _____ Pertussis _____

Immunization History (give month/date/ year) **** = required for all grades, unless otherwise noted***

DPT (or DTaP, DT, Td)	*	*	*	*	*
Polio (OPV or IPV)	*	*	*	*	
Hep B	*	*	*		
Varicella	*	*	*IF the students **HAD** chicken pox disease, please complete the box to the RIGHT*		
MMR	*	*	Hep A (2 doses required for **ALL** grades)	*	*
Below for students entering grades 6-12 only					
MCV4 (Meningococcal)	*(due gr 6-11)	*(2nd due gr 12)			
Tdap	*(due gr 6-11)				

For students entering grades **1-12,** who have had chicken pox (varicella), a ***healthcare provider*** signature and date of the occurrence is required**.**

_____

Provider signature

_____ **/** _____

Month/year

Please note that a parent report of disease history is not acceptable

Revised 03/24

Physical Examination

Student Name: _____ Height: _____ Weight: _____

Systems:	Findings:	Systems:	Findings:
General		Neurologic	
Skin/Hair		Endocrine	
HEENT		Extremities	
Cardiac		Postural Screening	
Respiratory		*Referral?	
GI/GU		Other	

Details on positive findings or additional comments:

_____

_____

Recommendations for correction or follow-up:

_____

_____

On the basis of today's examination,

I approve this child to take part in playground and gym activities. Y N

I approve this child to participate in interscholastic sports. Y N

Restrictions: _____

Physician Name: _____ Signature: _____ Date: _____