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

***For K entry and all new students, 2023/2024***

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 your 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 your child been tested for? Hearing: Y N Vision: Y N

**\*\*For K entry and all new students a vision screen is REQUIRED. Please have the healthcare provider sign, and give results (PASS/FAIL with ophthalmologist referral) \*\***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vision screen result**

For all new students or those entering **K** who have had chicken pox (varicella), a ***healthcare provider*** signature, and date of the occurrence is required.

**Provider signature**

**/**

**Month/year**

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

 Sickle Cell Anemia Y N results \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lead Poisoning Y N results \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your 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) | **\*** | **\*** | **\*** | **\*** |  |
| MMR | **\*** | **\*** | Hep A (2 doses required for **ALL** grades) | **\*** | **\*** |
| Hep B | **\*** | **\*** | **\*** |  |  |
| Varicella | **\*** | **\*** | *IF the students* ***HAD*** *chicken pox disease, please complete the box to the RIGHT* |

***\*This side to be completed by parent\**** *rev. 03/23*

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\*This side to be completed by provider****\**