

**THE FRANCISCAN SCHOOL
10000 ST. FRANCIS DRIVE
RALEIGH, NC 27613**

PHYSICAL FORM

Name _____ D.O.B. _____ Sex _____

Address _____ City/Zip _____

Home Phone _____ Grade entering in the fall _____

All children entering TFS for the first time must have a current physical on file within 30 days of their first day of school.

Parent's Signature / Date

Immunization Record

DPT _____

Polio _____

DT/TD _____

HIB _____

MMR _____

Hepatitis B _____

Varicella _____

TB Test Type _____ Date _____ Results _____

Please List Any Allergies: _____

Height _____ Weight _____ BP _____ HCT _____ Chol _____ Urine _____

Vision Screening - Test used _____ Results R _____ L _____

Hearing Test – Within Normal Range YES _____ NO _____ Referral Date _____

Developmental Evaluation – Test Used _____

Within Normal Limits _____ Needs Follow-up _____

Physical Examination

Please elaborate for abnormal results.

Skin/Nodes _____ Chest/Lungs _____ Muscular/Skeletal _____

Head/Neck _____ Heart/Circulation _____ Neurological _____

E.E.N.T. _____ Genital/Urinary _____

Please check any of the following illness or behavioral difficulties the child has or has had:

- | | | |
|----------------------------|-----------------------|----------------------------------|
| _____ Asthma | _____ Bleeding | _____ Cystic Fibrosis |
| _____ Bowel Problems | _____ Seizures | _____ Speech Problems |
| _____ Heart Problems | _____ Dental Problems | _____ Diabetes |
| _____ Ear Infections | _____ Meningitis | _____ Cancer/Leukemia |
| _____ Hearing Problems | _____ Skin Problems | _____ Digestive/Stomach Problems |
| _____ Bone/Muscle Problems | _____ ADD/ADHD | |

Does this child take medication on a routine basis? If yes, list medication and possible side effects.

Does any medication need to be given at school? _____ YES _____ NO

If yes, please complete Authorization to give Medication Form, indicating medication, time to be given, and dose.

List any medical, dental, developmental conditions, or disabilities which this child has and the extent to which these conditions might effect performance in school.

Has this child ever been hospitalized? If yes, please indicate when and what for.

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

Physican Name (please print) _____

Physician Signature _____ Date _____

Address _____

Phone _____