

GENERAL BROWN CENTRAL SCHOOL

PRE-SCHOOL PHYSICAL
HEALTH DEPARTMENT

Pupil's Name _____ Date of Birth _____

(To be completed by the family doctor)

Please indicate your findings in the spaces below:

Eyes - Strabismus _____ Heart _____ Orthopedic:
Blepharitis _____ Structural _____
Other _____ Lungs _____ Posture _____
Ears - Otosopic _____ Genito- _____ Feet _____
Urinary _____
Lymph Nodes _____ Hernia _____ Convulsive
Disorder _____
Nervous System _____ Speech _____ Skin _____
Thyroid _____ Tonsils _____ Allergies _____
Other _____

Does this child have any physical handicap? _____

Does this child take medicine regularly? _____

IMMUNIZATION RECORD

Polio					
Measles					
German Measles					
Diphtheria (DTP/Td)					
Tetanus Toxoid					
M/M/R					
Mumps					
Other (Specify)					

If any of the following tests are done, please give results and dates:

Urinalysis _____ Result _____ Tuberculin test _____ Result _____

Blood tests _____ Result _____ Chest X-Ray _____ Result _____

Is this child able to enter and participate in public school? Yes _____ No _____

Is this child able to participate in full Gym activity? Yes _____ No _____

Remarks: _____

Physician's Signature _____ Date _____