



Elkhart Christian Academy

ECA KINDERGARTEN PHYSICAL FORM (To be filled out by parent/guardian)

Student Name _____ Date _____
 (Please print) Last First Middle
 Grade _____ Age _____ Female _____ Male _____ Date of Birth _____
 Address _____
 Phone _____ Parent/Guardian Name _____

STUDENT MEDICAL HISTORY:

Please circle yes or no for each of the following questions: (If yes, please explain)

- YES NO 1. Has had injuries requiring medical attention.
- YES NO 2. Has had illness lasting more than a week.
- YES NO 3. Is currently under physician's care.
- YES NO 4. Currently taking medication: (please list) _____
- YES NO 5. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wears glasses or contact lenses)?
- YES NO 6. Does your child have any ear or hearing problems?
- YES NO 7. Does your child have any speech problems?
- YES NO 8. Does your child have any allergies (foods, insects, drugs, pollens, etc.)?
(Please list any allergies) _____
- YES NO 9. Does your child have any other specific sickness or problem which might affect his school performance?
- YES NO 10. Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting their health or educational needs?
- YES NO 11. Does this problem require any special health care in school?
- YES NO 12. Do you have any concerns about your child's developmental behavior or emotional well being of which the school should be aware?
- YES NO 13. Do you have any concerns about your child's general health?
- YES NO 14. Has your child had a dental check-up within the past six months?

Please explain any **Yes** answers to above questions _____

YES NO I give my permission for confidential and discreet use of any part of this form, to meet my child's health and educational needs.

 Parent/Guardian Signature Date

HEALTH EVALUATION

(To be completed by a Physician or Parent)

Name of student _____ Date of Birth _____

Name of doctor _____ Phone # _____

HISTORY OF IMMUNIZATIONS (Indicate month/day/year)

	1	2	3	4	5
DPT					
POLIO					
HIB					
HEPATITIS B	#1	#2	#3		
MMR	#1	#2	TB TEST	DATE	RESULT
VARICELLE					

TO BE COMPLETED BY A PHYSICIAN

1. Does this child have any health condition(s) which may require EMERGENCY ACTION while he/she is at school: (e.g. seizure, insect sting allergy, bleeding problem, diabetes, asthma, heart problem)?
__ YES __ NO (If yes, please describe) _____

PHYSICAL EXAMINATION

Significant past illness or injury _____
Grade _____ Age _____ Height _____ Weight _____ Blood Pressure _____

Examination	Satis	Unsatis	Not Examined	Examination	Satis	Unsatis	Not examined
Cardiovascular				Skeleton			
Respiratory				Abdomen			
Vision				Musculoskeletal			
Hearing				Skin			
Genitalia/Hernia							

2. Is this student on any long-term medication? (If yes, please explain) __ YES __ NO

3. Should there be any restriction of physical activity while at school? __ YES __ NO

ADDITIONAL NOTES AND INSTRUCTIONS

_____ has had a complete history and physical exam on _____
Student's Name _____ Date _____

Physician Name _____ Physician Signature _____
Print