

St. Mark School
Entrance Physical Exam Form

Child's Name _____ Birth Date _____

Address _____ Phone _____

PLEASE PROVIDE COMPLETE IMMUNIZATION RECORD.

PHYSICAL EXAM RESULTS

Please have your child's physician complete and sign this portion of the form.

Date of examination: _____

Height _____ Weight _____ Blood pressure _____ Pulse _____

Vision Results: OD _____ OS _____ Hearing: normal _____ abnormal _____

Blood Lead Level _____

CODE: O-NORMAL X-DEFECT ?-DOUBTFUL C-CORRECTED

NUTRITION: _____ NOSE: _____ LUNGS: _____

MOUTH&TEETH: _____ SKIN: _____ HERNIA: _____

NERVOUS SYSTEM: _____ EYES: _____ TONSILS: _____

HEART: _____ THYROID: _____ ORTHOPEDIC: _____

ALLERGIES: _____ OTHER DEFECTS: _____

Significant medical history including any abnormalities found: _____

Current medications or other forms of therapy:

If medication is required during school hours, please obtain a Prescribed Medication Form from the school office.

Immunizations received during this exam: _____

Doctor's Name (PRINT) _____ Address: _____

Doctor's Signature _____