Physical Examination *(to be completed by a licensed physician no more than 12 months before acceptance)*

Applicant's Name ____ Date : ____________________

LAST FIRST MIDDLE

Height (cm)	Weight (kg)	BP	Pulse	Vision-R	Vision-L	Vision- Both	Heart Screening	Blood Type

	Abnormal	Normal			Abnormal	Normal			Abnormal	Normal			Abnormal	Normal
Eyes				**Throat**				**Lungs**				**Skin**		
Ears				**Neck**				**Heart**				**Posture**		
Nose				**Nodes**				**Abdomen**				**Joints**		

STUDENT IMMUNIZATION RECORDS *(Please attach or complete schedule below)*

Type	Date 1st	Date 2nd	Date 3rd	Date	Date	Date
BCG (Tubercolosis)						
DPT (Diptheria, Petusis/ Tetanus)						
OPV (Oral Polio Vaccine)						
HIB (Haemophilous Influenza B)						
Hepatitis B						
Hepatitis A						
MMR (Measles, Mumps, Rubella)						
Varicella (Chicken Pox)						
Typhoid						
Cholera						
Tetanus						
Covid-19						
Others						

STUDENT'S MEDICINES AND ADDITIONAL INFORMATION

	Name	*Dosage*		*Name*	*Dosage*
colds			headache		
cough			fever		
allergies			asthma		

Medications / Supplements taken on a regular basis:

Has the child been hospitalized? ☐YES ☐NO If yes, reason for hospitalization and date:

Is the child able to participate in physical education activities? ☐YES ☐NO If no, please give reason:

Please indicate any specific medical condition of which the school should be aware:

Comments:

Other relevant information:

Printed Name of Physician:	Signature:	License No.	Date:
Address:			Office Telephone