HEALTH FORM 8006
South Texas Christian Academy

STUDENT PHYSICAL EVALUATION

(To be filled in by the physician)

Student Name________________________________Birth Date________________Sex_________
Address____________________________________Father's Name________________________
Mother's Name________________________
School South Texas Christian Academy

A. Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other?
Yes____ No___ Explain____
B. Does the student have any other medical problem with which the school should be concerned? Yes____ No___
Explain____
C. Is there evident need for dental care?
Yes____ No___ Explain____
D. Is there a hearing defect for which the school could help compensate by seating or other action? Yes___ No____
E. Has the student had a vision screening test? Yes___ No___ Date____________ Result__________
F. Are there ocular defect that indicate need for referral to an eye doctor? Yes______ No_____
G. Have there been illnesses, accidents, operations, or congenital defect that limit the students participation in:

a. Classroom activities? Yes___ No____ If so, explain______________________________
b. Physical Education? Yes___ No____ If so, explain______________________________
c. Swimming? Yes___ No____ If so, explain______________________________

H. Is there any mental, emotional or physical condition, for which the student should remain under periodic observation?
I. If so, explain____
J. At what intervals do the student need rechecks? ______________________________

**** DOCTOR: Please send a copy of the Immunization Records with this medical evaluation.**

PHYSICIAN'S RECOMMENDATION TO SCHOOL:____
____
____

I would like for the **SCHOOL ADMINISTRATION** to contact me regarding this student _____

DATE OF EXAMINATION:____________________
SIGNATURE:____

Office Address:____

Telephone:____

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STUDENT PHYSICAL EVALUATION CONTINUED

(To be filled in by parent/guardian before examination by physician)

1. Name of student__________________________Age________ Date of birth ____________
   Address______________________________________Telephone______________
   Fathers/Guardian Name____________________Mother's Name/Guardian_______________
   Whom to notify in case of illness (give address and phone numbers)__________________
   (A)___________________________ (B)___________________________
   Does the student live at home with parents?_____ Mother?____ Father?____ Other?_______________
   Does student have coverage by accident or hospitalization policy? (State type)-_______________

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2. Past illnesses (please -**check those**- the student has had)

_______Measles
_______Whooping cough
_______Polio
_______Rheumatic Fever

_______Scarlet Fever
_______Diphtheria
_______Chickenpox
_______Diabetes

______Heart Disease
______Chorea (St. Vitus' Dance)
______Epilepsy
______Hay fever or asthma

List any other serious illnesses, operations, or injuries and age when occurred:

1.____
2.____

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3. Has student ever been around anyone known to have tuberculosis? Yes____ No____
   a. Has he/she ever been tested for tuberculosis? Yes____No____
   b. Has he/she ever had a chest x-ray Yes____No____
4. When did the child last visit the dentist? Date_________________________(Recommend visit twice a year)
5. Has the Student has his eyes examined? Date__________________ By whom?____________________

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6. Comments on student's habits: How many hours of sleep does he usually get?_______________________
   a. Does he participate in outdoor activities? Not at all_________ Moderately_________ Continuously_______
   b. Does he prefer to watch TV to the above? Yes______ No______
   c. Eating Habits: Eats only at mealtime_____ In between meals occasionally_______ Frequently_________

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7. List any other items helpful to the school program in planning for students health:_______________________
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   ____
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