Lakewood Catholic Academy
School Entrance Physical Examination

Date of Physical: _____

Child's Name: _____
Address: _____ Phone # _____
Date of Birth: _____ Age: _____
Physician's Name: _____ Physician's Phone #_____
(Please Print)

Height _____ Weight _____

Vision R _____ L _____ Corrected R _____ L _____
Ears _____
Nose _____
Pharynx _____
Tonsils _____
Glands _____
Teeth _____
Heart _____
Lungs _____
Hernia _____
Skin _____
Allergies _____
Asthma _____
Neurological _____
Orthopedic _____
Scoliosis _____

Last T.B. test _____ Results _____

1. Pertinent Health information (include surgeries, hospitalizations, fractures, etc.)
_____
_____
2. Does this child receive daily medication? _____
If yes, what medication _____
3. Activity limitations _____
_____
4. Is child free of communicable disease? _____

Please state immunizations given at time of examination: _____
_____

****PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD****

Physician's Signature: _____ Date: _____

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