HEALTH EVALUATION FORM

Child's Name ____ DOB ______________________

Parent Name ____ Daytime Phone ____________________

Report of physical examination, to be completed by a physician

Date of last physical examination _________________________

Diagnosis ____

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Surgeries, accidents, illnesses, chronic or handicapping conditions ______________________________

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Medications, including dosage and time ____

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Allergies ____

Special dietary needs ____

Any limitations or restrictions at school ____

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Physical findings, including vision and hearing if done ____

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Recommendations ____

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Physician Name (print) ____

Phone Number ___________________________________ Fax Number _________________________

Physician's Signature _______________________________________ Date _______________________