

Community Christian Academy

PHYSICAL EXAMINATION

To be completed by Licensed Health Care Professional

Today's Date:	
Student's Name:	D.O.B.:
Height:	Weight:
Pulse:	Blood Pressure: /

Vision:	<input type="checkbox"/> Without Glasses	<input type="checkbox"/> With Glasses
Right: 20/	Left: 20/	

Screening	Normal	Abnormal	Comments
Head			
Skin			
Ears/Hearing			
Nose and Throat			
Teeth			
Heart			
Lungs			
Abdomen			
Neuromuscular System			
Extremities			
Spine (Scoliosis)			
Other			

General Condition
<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

Comments:

Medical Conditions, Chronic Diseases or Allergies
--

Comments:

Present Medications:

<input type="checkbox"/> This child may participate fully in school activities including physical education.
<input type="checkbox"/> This child may participate fully in Sports
<input type="checkbox"/> This child may participate in school activities including physical education with the following restrictions/adaptation:
Additional Comments:

Signature/Title of Health Care Provider:	Date:
Name: <i>(Please Print)</i>	Phone Number:

All new students are to have a physical exam on record and any student wanting to participate in sports.

Return form to:
 Registrar
 Community Christian Academy
 4706 Park Center Ave NE
 Lacey WA 98516
 Fax 360-412-0910
cca@foundationcampus.org