CHRIST SCHOOL

500 CHRIST SCHOOL RD, ARDEN, NC 28704

ANNUAL PHYSICAL EXAM

Student Name: _____ **DOB:** _____**Date of Examination:**_____

EXAM	PHYSICAL EVALUATION COMMENTS *(Note previous illnesses/injuries/hospitalizations)*	Follow-up
HEIGHT:		
WEIGHT:		
BP (sitting): **(standing):**		
PULSE: **RR:**		
LAB/URINE		
Sp. Gr.		
Glucose Protein		
Other		
LAB/BLOOD		
Hgb/Hct		
Glucose Other		
HEAD		
EYES (required)	**Acuity: _____(R)_____(L)**	
ENT		
DENTAL		
CHEST		
HEART		
ABDOMEN		
GENITILIA		
SKIN		
EXREMITIES		
BACK,NECK		
Other		

DRUG ALLERGIES: **FOOD ALLERIES:**

DIET RESTRICTIONS:

BY SIGNING THIS ANNUAL PHYSICAL FORM, I AM CONSENTING TO NO RESTRICTIONS or CONDITIONS TO STUDENT'S PARTICIPATION IN SCHOLASTIC/SPORT ACTIVITIES.

PHYSICIAN SIGNATURE: _____ Date: _____

Printed name and address: _____
Phone: _____ Fax: _____

Are you licensed to practice medicine in the United States? Yes_____ No_____

Please return this form by fax (828-684-7219) or email to nurse@christschool.org. Thank you.