PRE-ADMISSION HEALTH EVALUATION
PHYSICIAN'S REPORT

Statement to Physician

_____

Name of child **Birth date**

has applied to Holmesburg Christian Academy. This Academy provides a program three, four or five days a week. The daily activities include vigorous outdoor play, quiet indoor activities (of both a recreational and academic nature), and social interaction with other children. Please provide a report on the above named child using the form below.

_____

Parent or Guardian **Date**

Physician's Report

This report states that the applicant is in good health. It is implied that I have actually examined the child within a reasonable length of time (depending upon the health status of the child). The above named child is under my professional care and to my knowledge is physically and emotionally equipped to participate in the Early Childhood programs described above.

Is there any problem which might limit full participation in the Academy program?

Explain _____

Any serious illness, operation or injuries? If yes, explain and give age at which it happened.

_____

Are there any medications that will be expected to be given on a regular basis? _____

_____

HAS CHILD HAD (Please Circle):			DOES CHILD HAVE (Please Circle):		
HEAD INJURY	Yes	No	FREQUENT COLDS	Yes	No
EAR PROBLEMS	Yes	No	FREQUENT SORE THROAT	Yes	No
EYE INJURY OR DISEASE	Yes	No	ALLERGIES_____	Yes	No
ASTHMA	Yes	No	SPEECH DIFFICULTIES	Yes	No
CONVULSIONS/SEIZURES	Yes	No	EYE GLASSES	Yes	No
PULMONARY DISEASE	Yes	No	HEARING LOSS	Yes	No
CHICKEN POX	Yes	No	CHRONIC COUGH	Yes	No
MEASLES	Yes	No	VISION DIFFICULTIES	Yes	No
GERMAN MEASLES	Yes	No	BEHAVIOR PROBLEMS	Yes	No
MUMPS	Yes	No	EMOTIONAL PROBLEMS	Yes	No
SCARLET FEVER	Yes	No	OTHER _____	Yes	No
OTHER _____	Yes	No	OTHER _____	Yes	No

(over)

THE COMMONWEALTH OF PENNSYLVANIA REQUIRES ALL CHILDREN TO BE IMMUNIZED BEFORE ENTERING SCHOOL. PLEASE COMPLETE THE FOLLOWING INFORMATION:

VACCINE **Circle appropriate item**	**Enter Month, Day, and Year Each Immunization Was Given** **DOSES**				
Diptheria and Tetanus (DTaP, DTP, Td or DT)	**1.** / /	**2.** / /	**3.** / /	**4.** / /	**5.** / /
Polio (OPV or IPV)	**1.** / /	**2.** / /	**3.** / /	**4.** / /	**5.** / /
Hepatitis B	**1.** / /	**2.** / /	**3.** / /		
Measles – Mumps – Rubella (MMR)	**1.** / /	**2.** / /	Or Measles Serology:	**Date:**	**Titer:**
Varicella (Vaccine or Disease)	**1.** / /	**2.** / /	Rubella Serology:	**Date:**	**Titer:**
Other	**1.** / /	**2.** / /	Mumps Disease Diagnosed by Physician	**Date:**	

*MMR'S MUST BE GIVEN ON OR AFTER THE FIRST BIRTHDAY

TUBERCULIN TEST DATE: _____RESULTS _____

	LEFT	RIGHT	COMMENTS
VISUAL SCREENING			
HEARING SCREENING			

IS THE CHILD ON ANY MEDICATION?_____ REASON_____

Name _____Dosage _____ Times _____

Doctor's Name _____Phone_____

Office Address _____

Hospital Affiliation _____

Doctor's Signature _____Date _____

This form must be completed and returned to school prior to your child's attendance at Holmesburg Christian Academy.