WHISPERING PINES SEVENTH-DAY ADVENTIST SCHOOL

SCHOOL HEALTH FORM - PHYSICIAN'S CERTIFICATE

THIS FORM IS TO BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR

Student's Name: ________________________ DOB: ____________________

Height: ________________________ Weight: ____________________

Body Mass Index: ______________

Weight Status Category (BMI Percentile):

☐ Less than 5 ☐ 5th - 49th ☐ 50th - 84th

☐ 85th - 94th ☐ 95th - 98th ☐ 99th & Higher

Vision without glasses/contact lenses

R	L	

Vision with glasses/contact lenses

R	L	

Vision—Near Point

R	L	

Hearing ☐ Pass 20db sc both ears or:

R	L	

Blood Pressure: ____________

Nutrition: ____________

Teeth and Gum: ____________

Glands—Cervical: ____________

Heart and Lungs: ____________

Orthopedics:
Spinal Deviation ____________

Genitalia (male): ____________

Nervous System: ____________

Speech: ____________

Tonsils and Throat: ____________

Thyroid: ____________

Skin: ____________

Scoliosis: ____________

Feet: ____________

Urinalysis: ____________

Does this child have any condition requiring on-going medical care? ☐ YES ☐ NO

Specify: ________________________________

Does this child have a defect or disability? ☐ YES ☐ NO

Specify: ________________________________

Are there any issues relating to the growth, development and nutrition? ☐ YES ☐ NO

Specify: ________________________________

Should any restrictions be placed on this child's participation in physical activities? ☐ YES ☐ NO

Specify: ________________________________

Does this child take any medication (other than vitamins) on a regular basis? ☐ YES ☐ NO

Specify: ________________________________

Are there any other medical issues? ☐ YES ☐ NO

Specify: ________________________________

Immunization:	**Date of Administration:**	**Immunization:**	**Date of Administration:**
Polio/OPV	1_______ 2_______ 3_______	MMR	1_______ 2*_______
DPT/DTAP	1_______ 2_______ 3_______	Mantoux	1_______
TD	1_______ 2_______ 3_______	(within 1 year)	(required for new entrants including the results)
TDAP	1_______		
HIB	1_______ 2_______ 3_______	Varicella	1_______
HEP B	1_______ 2_______ 3_______	*Necessary for children born on or after 1/1/85	
PCV	1_______ 2_______ 3_______ 4_______		

Signed: ____________________ Title: ____________________

Address: ____________________ License: ____________________

Telephone #: ____________________ Date of Exam: ____________________