Today's Date____________________

Name__________________________ Sex__________ DOB___________

Address______________________________________ Phone___________

____

School_______________________________________ Grade___________

Parent or Legal Guardian	Employer

Past Illness: Please check if your child has had any of the following:

Allergies	Asthma	Diabetes
Hepatitis	Convulsive Disorders	Heart Disease
Lyme Disease	Drug Sensitive	Eye Trouble
Scarlet Fever	Tonsillitis	Behavior Problems
Strep Infections	Rheumatic Fever	Injuries
Mononucleosis	Chicken Pox	Operations:
Pneumonia	Ear Infections	

Immunizations

	Date #1	Date #2	Date #3	Date #4	Date #5
DPT/DT					
Polio					
MMR					
Hib					
Hepatitis B					
Varicella					
Influenza					
Pneumoccocal					

If your child is presently receiving care for any physical condition or takes medication on a regular basis, please note: ____

Please feel free to contact the school nurse if you have any questions to discuss or information to share.

Signature of Parent or Legal Guardian:____

Updated 3/4/'08

Lighthouse Christian Academy
400 Beach Ave.
Manahawkin, NJ 08050
Phone: 609-597-3915 Fax: 597-9659

Physician's Examination

Date of Examination______________________

Student's Name:_________________________

Student's Address________________________

____

Physician's Name_________________________

Physician's Address_______________________

____

Phone:________________________________

Physical Examimation

Eyes_________ Ears__________

Nose_________ Throat________

Teeth________ Skin__________

Glands_______ Heart_________

Lungs________ Abdomen______

Genitalia______ Hernia_________

Nervous System________ Joints__________

Blood Pressure_________________________

Height__________ Weight_________

Orthopedic

Flat feet_________________________________

Scoliosis

Degree of Curve	Type of Curve
1. Less than 10	1. Thoracic________
2. 11 to 20	2. Double Major____
3. 21 to 40	3. Thoracolumbar___
4. 41 to 55	4. Lumbar_________
5. More than 55	5. Other___________

Snellen Eye Test

__________________________with glasses

__________________________W/O glasses

Results Right eye______________

Left eye _______________

Both _____________

Additional Physician Comments:_________

____

____

____

____

____

____

Date Physician's Signature