SAINT ROSE
CATHOLIC SCHOOL

# Physician's Report

Child's Name: _____ Birth Date: _____ Male _____ Female _____

**Immunizations:** **(Pre-Kindergarten)** 4DPT, 3 Polio, 1 MMR, 3 Hepatitis B, & 4 HIB
**(Kindergarten)** 5DPT, 4 Polio, 2 MMR, 3 Hepatitis B, 2 Varicella

DPT 1_____ 2_____ 3_____ 4_____ 5_____

Polio 1_____ 2_____ 3_____ 4_____ 5_____

MMR 1_____ 2_____

Hep B 1_____ 2_____ 3_____

HIB 1_____ 2_____ 3_____ 4_____

Varicella 1_____ 2_____

Other Type_____ Date_____ Type_____ Date_____

**Screening Tests:**

Vision (Pass/Fail)
Distance Acuity R _____ L_____
Muscle Balance R _____ L_____
Farsightedness R_____ L_____
Color (Pass/Fail)
Glasses (Yes/No)

Hearing (Pass/fail)
Pure Tone R_____ L_____
Impedance R_____ L_____
Frequent Ear infections? _____
Tubes R_____ L_____
Dates Places R_____ L_____

**Physical Exam:**

Essentially normal: _____ Abnormalities as follows:_____

Is this child able to participate in all school activities? Yes _____ No_____
If no, please explain: _____

This is to certify that the above named student has been seen in our office and is in suitable condition to attend a preschool or kindergarten program. (Print or stamp below)

Signature:_____
Date of Exam:_____
Phone:_____

Physician Name: _____
Address: _____
_____