THE NEWMAN SCHOOL

Physical Examination Form

All students are required to have an ANNUAL physical examination by a licensed practioner prior to enrollment. The examination should be no older than six months and preferably the summer prior to the start of the school year. Students will NOT be admitted into the classroom

Student's Family Name: _____

Student's First Name: _____

Date of Examination: _____

Physical Examination by Physician

Height	_____	Extremities	_____	Weight	_____
Teeth	_____	Abdomen	_____	Pulse	_____
Urianalysis	_____	Heart	_____	Eyes	_____
Ears	_____	Lungs	_____	Throat	_____
Thorax	_____	Spine	_____	Blood Pressure	_____
Nose	_____	Tonsils	_____		

Please indicate significant Medical History, especially within the last year by placing an X under Y (yes) or N (no). If treatment is to be continued, provide an explanation of the illness(es) and a full description of the treatment/s.

	YES	NO
Mumps	____	_____
Kidney Problems	_____	_____
Measles	_____	_____
Migraines	_____	_____
Eye Problems	_____	_____
Cerebral Palsy	_____	_____
Asthma	_____	_____
Hepatitis A	_____	_____
Typhoid Fever	_____	_____
Diphtheria	_____	_____

Heart Problem	_____	_____
Mononucleosis	_____	_____
Hearing Problem	_____	_____
Muscular Dystrophy	_____	_____
Congenital Diseases	_____	_____
Hepatitis B	_____	_____
Scarlet Fever	_____	_____
Epilepsy	_____	_____
Meningitis	_____	_____
Pneumonia	_____	_____
Rheumatic Fever	_____	_____
Cancer	_____	_____
Pregnancy	_____	_____
Hepatitis C	_____	_____
Arthritis	_____	_____
Polio	_____	_____
TB	_____	_____
Diabetes	_____	_____
HIV	_____	_____
Bronchitis	_____	_____
SARS	_____	_____
Hepatitis D	_____	_____

Please type/print an X for your response:

1) Are there any physical limitations? YES _____ NO _____
   (Physical limitation must be specified and documented by a physician)

2) Is there any history of emotional or psychological incidents? YES ____ NO ____
   (If yes, please explain the incident(s), its treatment(s), and the prognosis)

3) Does the student take any prescribed medications? YES ____ NO ____

(If yes, please complete the enclosed Physician's Medication Order for any prescription medication to be dispensed by the school nurse or by a host family. The physician's medication order must include dose, frequency, and purpose for each medication and must be signed by the physician)

4) Does the student take any over-the-counter medications? YES ___ NO ____
   (If yes, any over-the-counter medication to be dispensed requires a signed parental permission or physician's order including dose, frequency, and purpose.)

5) Allergies YES ____ NO ____
   (If yes, please indicate types, medications, and treatments. A physician's medication order must be on file for inhalers.)

6) Has the student been hospitalized in the recent past? YES ____ NO _____
   (If yes, please indicate the diagnosis and treatment.)

Student are NOT allowed to self-medicate. All substances must be administered by the School Nurse or Host Parent.

Is the student is fit to participate and engage in sports? YES ____ NO_____

Physician's Name (English): _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Physician's Signature (English): _____

Date: _____