# New Springs Christian Academy
# Physical Examination Report

Student Name_____ Grade_____

Parent(s) Name_____ Date of Birth_____

Address_____ Phone_____

Medical Conditions of Concern to School Personnel:

Any Physical Limitations or School Activity Restrictions:

Prescribed Medications:

Vision R 20/_____ L 20/_____

Hearing R ear_____ L ear_____

**Immunizations: List all immunizations given to date, including infant immunizations.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| DTP/DtaP/DT/Td | 1. | OPV/IPV | 1. | MMR | 1. | Hepatitis B | 1. |
| DTP/DtaP/DT/Td | 2. | OPV/IPV | 2. | MMR | 2. | Hepatitis B | 2. |
| DTP/DtaP/DT/Td | 3. | OPV/IPV | 3. | HIB | 1. | Hepatitis B | 3. |
| DTP/DtaP/DT/Td | 4. | OPV/IPV | 4. | HIB | 2. | TB Test/Result | |
| DTP/DtaP/DT/Td | 5. | OPV/IPV | 5. | HIB | 3. | Varicella Vaccine | |
| Td Booster | | | | HIB | 4. | Chicken Pox Disease | |

I would like the teacher to contact me regarding this child. (if applicable, circle) YES

Physician's Name (please print): _____

Date of Examination_____ Examining (child's name): _____

Physician's Signature: _____

Phone_____

Address_____

**Please return to New Springs Christian Academy**
604 Elm St. Neenah, WI 54956
office@newspringswi.com
920-215-3384