CROSSROADS CHRISTIAN SCHOOL

PO Box 249 ♦ Henderson, NC 27536 ♦ (252) 431-1333 Office ♦ (252) 431-0333 Fax ♦ www.ccscolts.org

Student Medical Information – Part B (Physician's Form)

To be completed by student's physician (new students)

Student: _____ Birth Date: _____

Name of Parent or Guardian: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

PHYSICAL EXAMINATION (To be completed by a licensed physician, a certified nurse practitioner, or a public health nurse)

Height ____ % Weight _____ % Head _____ Eyes _____ R _____ L _____ Both Ears _____

Nose _____ Teeth _____ Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____

Ext _____ Skin _____ Neurological System _____ Should activities be limited? _____

Explain: _____

Results of Tuberculin Test, if give: Type _____ Date _____ Normal _____ Abnormal _____

Examiner's Signature/Title _____

Phone _____

IMMUNIZATION RECORD (the health official must enter the date immunizations were received in the space below or attach a copy of the immunization record.)

TYPE OF VACCINE	#1	#2	#3	#4	#5
*DPT OR DT (circle one)					
*Polio					
** Hib					
*MMR (combined doses)					
*** Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
*** Hep. B (three doses)					
Other					

***Required by State Law **Required by State Law if born on or after 10-01-91 ***Required by State Law if born on or after 7-01-94**

NOTE: If there are any changes in a student's health history, it is the responsibility of the parent/guardian to notify the school and submit a new "Student Medical Form" as soon as possible.

_____ _____

Parent Signature **Date**