



Part A: to be completed by the parent/guardian prior to examination

Please note that if your student is an athlete with an athletic physical on file with Granville Christian Academy, you can complete the parent portion of this form and return it with a copy of the athletic physical and immunization records to the school. The parent does not need two physician physicals completed.

Student Name: _____
Address: _____
Mother's Name: _____ Father's Name: _____
Grade Entering: _____ Birth Date: _____
Gender: _____ Place of Birth: _____
Phone: _____

- Has the student ever:
- Been hospitalized? Yes No
 - Had surgery? Yes No
 - Had injury requiring serious medical attention? Yes No
 - Had illness requiring serious medical attention? Yes No
 - Had a diagnosed concussion? Yes No
 - Had a physician place activity limits in P.E. class or in sports? Yes No
 - Lost consciousness or passed out during physical activity? Yes No

- Does this student:
- Have any known allergies to medication, foods, bee stings, other? Yes No
 - Have dietary restrictions? Yes No
 - Have a chronic disease, adaptive equipment, or daily medical needs? Yes No
 - Have frequent headaches? Yes No
 - Have frequent stomachaches? Yes No
 - Have frequent sore throats? Yes No
 - Have frequent nosebleeds? Yes No
 - Does this student wear glasses or contact lenses? Yes No

If you answered yes to any of the above questions, please specify the details below for this student:

Currently under the care of a physician for: _____
List allergies (to medication, foods, environmental, etc.): _____
Currently takes the following daily or "as needed" medications: _____
List of dietary restrictions: _____
List any injury or illness requiring hospitalization: _____
List how many total concussions and dates of diagnoses: _____
Explain "yes" answers to any other question from above: _____

Parent Signature: _____ Date: _____

Please see the school Nurse for additional required forms if medications need to be available at the school for your child.

Part B: to be completed by the student's licensed healthcare provider

This student has been evaluated in regard to his/her health with the following results:

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____
 Urinalysis (if performed) Albumin: _____ Sugar: _____
 Blood Count (if performed) HgB: _____ Hct: _____
 Visual Acuity Right: _____ Left: _____
 Auditory Acuity: Right: _____ Left: _____

Physical Development and Health: Normal: _____ Abnormal as follows: _____
 Intellectual Development: Normal: _____ Abnormal as follows: _____
 Emotional Development: Normal: _____ Abnormal as follows: _____

Examination of:	Satisfactory Result	Unsatisfactory Result	No Exam Performed
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Respiratory			
Cardiovascular			
Abdomen			
Genitalia			
Skin/Lymph Nodes			
Musculoskeletal			
Neurological			
Other			
Lab Test (Specify Here)			

If any of the above are marked "unsatisfactory" or "no exam", please explain:

Immunizations

Provide a printed copy of the student's immunization records with the month, day, and year for each immunization given. A written copy of the record can be attached to this document as well. Required immunizations are: DTaP or DTP or DT, Tdap/Td, POLIO, MMR, HEPATITIS B, VARICELLA, HIB (prior to age 5), MENINGOCOCCAL, HPV, HEP A.

Sign here if the student is to be exempted from the required immunizations for medical reasons:

Physician's signature

Date

I certify that I have examined this student as indicated and, on the basis of the information furnished to me, find him/her free of communicable disease and physically able to participate in all supervised school activities and sports (please provide a separate document with exceptions to this statement).

Licensed Healthcare Provider

Printed Name

Signature

Date of Exam

Phone

Return completed form to:
 Granville Christian Academy: Attention Enrollment Director
 1820 Newark Granville Road
 Granville, Ohio 43023

Forms can also be returned to admissions@granvilleca.org.