

School: OUR REDEEMER LUTHERAN SCHOOL
To be filled out by family physician - - return form to school

NAME: _____ DATE: _____
DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

Eyes:	Right _____	Left _____
Vision:	Right _____	Left _____
Ears:	Right _____	Left _____

Allergies (list): _____

Nose: _____

Mouth and Throat: _____

Neck: _____

Lymph Glands: _____

Heart: _____

Lungs: _____

Abdomen: _____

Hernia: _____

Skin: _____ Scalp: _____

Urine: _____ Sugar: _____ Albumin: _____

Hemoglobin: _____ Hemotocrit: _____

Posture: _____

Neuro-Muscular: _____

Emotional Stability: _____

Summary of Defects: _____

Remarks and Recommendations: _____

Any Limitations of Activities: _____

Student on Medication? _____ If so, what kind and dosage? _____

Physician's Signature