MERCY HEIGHTS CATHOLIC NURSERY & KINDERGARTEN

211 San Vitores St., Perezville-Tamuning, GU · Tel: (671) 646-1185 · Fax: (671) 649-1822 email:mhcnk211@gmail.com

PHYSICAL EXAMINATION FORM

Child:_____ Birthdate:_____
Child's Home Address:_____ Home Phone:_____
Father:_____ Home Address:_____
Contact Numbers (Home)_____ (Work)_____(Cellphone)_____
Mother:_____ Home Address:_____
Contact Numbers: (Home)_____ (Work)_____ (Cellphone)_____
Guardian:_____ Home Address:_____
Contact Numbers: (Home)_____ (Work)_____ (Cellphone)_____

Medical History

1. Any history of Allergy? ☐ No ☐ Yes what?_____
2. Any previous illness? ☐ No ☐ Yes what?_____
3. Any history of hearing problem? ☐ No ☐ Yes, what?_____
4. Any history of convulsion? ☐ No ☐ Yes, what? _____

GENERAL INSPECTION

Head:_____
Eyes:_____
Ears:_____
Nose:_____
Mouth:_____
Throat:_____
Teeth:_____
Neck:_____
Chest:_____
Heart:_____
Lungs:_____
Abdomen:_____
Spleen:_____
Genitalia:_____
Hernia:_____
Extremeties:_____
Neurogical System:
_____

Does this child have significant problems (physical, social, or emotional) which will interfere with his/her school activities?
No:_____
Yes:_____
What?_____
_____

Remarks, Recommendation or restriction if any:_____
_____
_____
_____

PHYSICAL EXAMINATION

Height:_____
Weight:_____
Temp:_____
Pulse:_____
Respiration:_____
Blood Pressure:_____
Vision: Left:___ Right:___

IMMUNIZATION HISTORY

Please fill in the dates administered:

Vaccine, DTP:
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

TOPV
(1)_____
(2)_____
(3)_____
(4)_____
(5)_____

(Measles, Mumps, Rubella)
(1)_____
(2)_____

TETRAMUNE (DTP/HIB)
(1)_____
(2)_____
(3)_____
(4)_____

0r HIB
(1)_____
(2)_____
(3)_____
(4)_____

HEP B
(1)_____
(2)_____
(3)_____

PPD
Date Given:_____
Date Read:_____
Result:_____

_____
Date of PHYSICAL EXAM

_____
CLINIC/HOSPITAL NAME

_____
EXAMINER'S SIGNATURE

_____
PRINT NAME & TITLE

MMR