

# The Country Day School

449 Rose Hill Drive • Kearneysville, West Virginia 25430

304-725-1438 • Fax: 304-728-8394

www.thecountrydayschool.com



Reason • Responsibility • Respect

## MEDICAL FORM

Name \_\_\_\_\_ Sex \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Significant History: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**Immunizations or Boosters**      **Date**    **Date**    **Date**      **Disease Experience**

1. DTap/DTP/Td/Tdap (4) \_\_\_\_\_

2. Hep B (3) \_\_\_\_\_

3. MMR (2) \_\_\_\_\_

4. Polio (IPV) (3) \_\_\_\_\_

5. Varicella (2) \_\_\_\_\_

6. Hep A (2) \_\_\_\_\_

7. Hib (3) \_\_\_\_\_

8. PCV (4) \_\_\_\_\_

9. TB Skin Test (*Required if moving into WV from out-of-state*) \_\_\_\_\_

## RECORD OF PHYSICAL EXAMINATION

Ears: \_\_\_\_\_

Eyes: \_\_\_\_\_

Nose: \_\_\_\_\_

Throat: \_\_\_\_\_

Teeth and Gums: \_\_\_\_\_

Heart: \_\_\_\_\_

Name \_\_\_\_\_  
(Last) (First) (Middle)

Lungs: \_\_\_\_\_

Posture: \_\_\_\_\_

Orthopedic Defects: \_\_\_\_\_

Skin and Scalp: \_\_\_\_\_

Nervous System: \_\_\_\_\_

Hearing Screen:  Pass  Fail Vision Screen: :  Pass  Fail

Other Medical Conditions (including Speech): \_\_\_\_\_

Athletic Limitations: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Please state any contagious diseases, operations, or severe illness this child has had during the past year: \_\_\_\_\_

Please state any contributory health factors that need guidance with respect to school work: \_\_\_\_\_

This is to certify that I have examined the above-named student and have found him/her in good general health and free from all infectious and contagious diseases. He/she may participate in the athletic program (except as stated above).

Physician's Name, Address and Telephone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

06/09