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(210) 822-5374

MacArthur Park Lutheran School

www.macparkschool.org
macparkschool@gmail.com
macparkschooloffice@gmail.com

ALL STUDENTS MUST HAVE A PHYSICIAN COMPLETE THE FOLLOWING:

This child (name), ______________________________________, was examined by me on _________ and found to be free of all contagious and transmissible diseases and is able, with exceptions noted below, to participate in the school program. This child's immunizations are current.

Date of Health Exam: __________________ Weight @ exam: _____________________________

Physical Exam: ___Normal ___Abnormal (Specify any physical abnormalities) _________________

Allergies: ___No ___Yes:_______________________ Type of Reaction _________________________

Significant Health Concerns: ___ Severe Allergies ___ Reactive Airway Disease ___Asthma ___Seizures

___Diabetes ___Developmental Delays ___Behavior Concerns ___Vision ___Hearing ___Dental

___Nutrition ___Other__________________________

Explain above concern (if necessary, include instructions to care providers):

____

Doctor Signature ______________________________________ Date _______________

IMMUNIZATIONS: ___Up to date- Please attach immunization record

□ Immunizations Administered today: ______________________________

HEARING/VISION SCREENING:

Hearing and Vision screenings are required by the state for students FOUR YEARS OLD AND OLDER.

VISION SCREENING

Distance Acuity:

Right 20/_____________

Left 20/_____________

________Pass ________Fail/Rescreen

HEARING SCREENING

@25 DB	Right	Left
Hz 500	_____	_____
1000	_____	_____
2000	_____	_____
4000	_____	_____

Signature _______________________________________ Date ________________