



2020-2021 SCHOOL YEAR
PRIVATE PHYSICIAN'S REPORT OF PHYSICAL EXAMINATION

DATE _____

Please Return to:
THE HERITAGE SCHOOL
651 NORTH WAYNE AVE.
WAYNE, PA 19087
FAX: 610-989-0591
Email: heritage@coswayne.org

Name of Child _____ Date of Birth _____ Sex _____

Address _____

MEDICAL HISTORY -- Give significant details, including serious illnesses, allergies, operations, accidents, etc.
A separate Emergency Action Plan form must be filled out for children with severe allergies.

Have immunizations required by law been administered? YES _____ NO _____

Please attach a copy of the immunization record and health summary from the doctor's office

Does this patient have any mental impairment? YES ___ NO ___ If yes, are they under treatment? YES ___ NO ___

Should child have restrictions on play or physical education activities? YES ___ NO ___

If yes, what should these restrictions be?

Signature of examining physician _____ Date _____

Name, address, and telephone number of physician: (PLEASE PRINT)

A RECORD OF IMMUNIZATIONS MUST BE ATTACHED TO THIS EXAMINATION FORM. THANK YOU!