THE HARBOUR ISLAND GREEN SCHOOL

FORM C:
PHYSICIAN'S REPORT

To be completed by a Physician or Family Nurse Practitioner:

PERSONAL DATA

STUDENT'S NAME:_____

DATE OF BIRTH:_____

HEIGHT: (CM) WEIGHT:_____(LB) BP: _____

GENERAL APPEARANCE: _____

NUTRITIONAL STATE:_____

SKIN:

HAIR/SCALP: _____

EYES: _____ VISION: R L
(indicate whether tested with glasses or not)

EARS:_____ HEARING: _____

NOSE/THROAT: _____

THYROID: _____

RESPIRATORY SYSTEM: _____

CARDIOVASCULAR SYSTEM:_____

ABDOMEN/GI SYSTEM:_____

CENTRAL NERVOUS SYSTEM: _____

BONES AND JOINTS:_____

DEFORMITIES/DISABILITIES: _____

Other Investigations Indicated: _____
(Follow up report to be provided if necessary)

IMMUNIZATION HISTORY Please indicate dates vaccines received.

	DOSES				
Vaccine	**1st**	**2nd**	**3rd**	**Booster 1**	**Booster 2**
BCG					
DPT/DT					
Polio					
MMR					
Chicken Pox					
Hep. B					
Hib					
Pneumovax					
Other:					
Other:					

***Please provide a copy of the immunization card for the school record**

REMARKS AND RECOMMENDATIONS: _____

_____

_____

_____

Certified Fit For Admission To School: Yes ( ) No ( )

_____ _____

Doctor's Signature Address Of Health Centre

_____ _____ _____

Doctor's Name (Written) Mcj Reg. # Date

OR:

_____ _____

Nurse Practitioner's Signature Address Of Health Centre

_____ _____ _____

Nurse Practitioner's Name (Written) Ncj Reg # Date