REGINA COELI CHILD DEVELOPMENT CENTER
PHYSICAL EXAMINATION FORM

Name:_____ Birth Date___/___/___/

Address:_____ S.S. No.___ ___ ___

Position in Head Start:_____

Health History:
Have you ever been treated for the following:

Yes	No		Yes	No	
___	___	head or spinal injury	___	___	asthma
___	___	heart disease	___	___	tuberculosis
___	___	diabetes	___	___	ulcers
___	___	kidney disease	___	___	other

If answer to any of the above is yes, explain:_____

_____

_____

History of previous illnesses or injuries:_____

_____

_____

Physical Examination:

Height_____ Weight_____ Blood Pressure_____

T. B. Skin Test: Date:_____ Positive_____ Negative_____

1. Eyes: Visual acuity R_____ L_____ Glasses:_____Yes _____No

2. Ears: Right_____ Left_____

3. Heart:_____ Lungs:_____

4. Communicable disease:_____

5. Extremities:_____

6. Spine:_____

This individual _____is ____is not able to perform the duties of the above named position in Head Start.

Comments:_____

_____

Date:_____ Signed:_____
Physician

PHYSFORM-8-95