ASCENSION EPISCOPAL SCHOOL
2525 Seagler Rd. Houston, TX 77042
713-783-0260 / **Fax 713-787-9162**

PHYSICAL FORM

2018 - 2019

Each required section must be completed and a U.S. physician must sign and date this form.

Student's Last Name ______ First Name ______ Date of Birth (month/day/year) ______ Grade (2018-2019) ______

PHYSICAL EXAMINATION {Required for ALL STUDENTS each year.} ______ Date of Last Exam

Current Height _______ Current Weight ______ Blood Pressure _____________ Respiratory Rate _____ Pulse ________

SPINAL SCREENING {Required for all NEW students.}

Passed _____________ Failed _____________ Follow-up _______________ Referred ______________________

Signature of Screener ____ Date ___________________________

VISION SCREENING {Required for all NEW students and for students entering grades PK4, K, 1st, 3rd, and 5th.}

Right Eye 20/_______ Left Eye 20/ _______ Passed _____ Failed ______ Follow-up ______________________

Signature of Screener ____ Date ___________________________

HEARING SCREENING {Required for all NEW students and for students entering grades PK4, K, 1st, 3rd, and 5th.}

Right Ear: Passed __________ Failed _______ Follow-up ______________ Referred ______________________

Left Ear: Passed ___________ Failed _______ Follow-up ______________ Referred ______________________

Signature of Screener ____ Date ___________________________

DIABETES SCREENING Type 2/Visual Neck Screening
{Required for all NEW students and for students entering grades 1st, 3rd, and 5th.}

Passed ______ Failed______ BMI _______ Follow-up _______________ Referred ______________________

Signature of Screener ____ Date ___________________________

IMMUNIZATION REQUIREMENTS FOR ALL STUDENTS

Vaccine	
DTP/DTaP	
Polio	
HIB	
Measles	
Mumps	
Rubella	
MMR	
*Varicella (Chicken Pox)	
Hepatitis A	
Hepatitis B	

New Students – *Please attach a current copy of all your child's immunization records to this form.*
Returning students – *Must submit* ***updated immunization*** *records with each new vaccine obtained.*

This section must be completed for children 2years of age or older.

Varicella (chicken pox) vaccine date ____________________________ (mandatory August 2000)

This is to verify that _____________________________ had varicella disease on or about ____________
Student Name *Date*
and does not need varicella vaccine. _______________________________
Physician or Parent Signature

I certify that on this date I have examined the above mentioned student and find that he/she is in good health, is free of contagious disease, is up-to-date on all immunizations required by the State of Texas and is physically able to participate in supervised physical activities and/or join an athletic team. Exceptions:____

Physician's Signature ____ Date ___________________________