All Saints Catholic School Registration

419 6th Avenue, Antigo, WI 54409
715-623-4835 (phone)/715-623-3202 (fax)

Physical Examination Form

Child's Name _____ Date of Birth _____

Address _____

Parent's Name _____/_____
(Mother) (Father)

Date of Physical Examination: _____

Vision:
Primary Care Office Screen (can be done by optometrist or ophthalmologist):

Left eye 20/____ Right eye 20/____ Both eyes 20/____

Recommendations:_____

Optometrist or Ophthalmologist signature (if exam done there): _____
(Date if done other than with physician: _____)

Hearing Screen: Normal _____ Abnormal _____

Medical Problems:

_____

_____

Medications:

_____

_____

Need for Assistant Devices:

_____

_____

Physical Exam:

Normal exam (no signs of problems to restrict activity in school or infectious disease) _____
Abnormal exam (please list pertinent findings)

_____

_____

_____

Restrictions for activities in school

_____

_____

_____

Physician (or P.A. or N.P.) Signature: _____
Name of Medical Facility: _____

ALL SAINTS CATHOLIC SCHOOL
419 6th Avenue
Antigo, WI 54409
715-623-5629
FAX 623-3202

DENTAL REFERRAL FORM

SCHOOL _____ GRADE _____ DATE OF BIRTH _____

NAME OF CHILD _____

PARENT OR GUARDIAN _____

To the Parent/Guardian:
Your school has a health program that is designed to improve, protect, and promote the health of each child. As a part of this health program, we strongly urge you to take your child to a dentist of your choice for a dental examination and whatever treatment may be necessary.

To the Dentist:
Check one of the following statements before signing this form:

_____ 1) No dental work necessary.

_____ 2) All immediate dental work has been completed.

Date _____ SIGNATURE OF DENTIST _____