

**GOOD SHEPHERD EPISCOPAL SCHOOL
MEDICAL CERTIFICATE**

REC'D _____

SNAP _____

Please take this form with you for your child's annual physical.

PLEASE NOTE: An annual exam by a Licensed Physician or Nurse Practitioner is required for all grades and is valid for 12 months from the date of the exam.

New students must return the completed form by JULY 1ST.

Parent/Guardian Section

Student's Name _____ Upcoming Grade _____

New Student? ___ Re-Enrolling Student? ___ Birthdate ____/____/____

After July 1st, please enter **Allergies, Asthma, Medications, Surgeries, Diagnosis** or any other important health history, please enter details on the SNAP Health Portal at: www.studentehr.com

**Food Allergy Plan, Asthma Action Plan or Medication Permission Form (for daily medications received at school) should be returned to the School with applicable medications. Links to forms can be found on Step-by-Step Enrollment / Re-Enrollment Instructions.

If you have any questions, please email clinic@gsesdallas.org

Physician Section

Please attach completed current immunization record to this form.

Date of Exam _____ Height _____ Weight _____ B/P _____ BMI _____

	WNL	ABN		WNL	ABN	Hearing @25dB		
	or	or		or	or	1K	2K	4K
	NEG	POS		NEG	POS			
Skin.....	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia(males only).....	<input type="checkbox"/>	<input type="checkbox"/>	Right	_____	_____
Head.....	<input type="checkbox"/>	<input type="checkbox"/>	Extremities.....	<input type="checkbox"/>	<input type="checkbox"/>	Left	_____	_____
Eyes, Ears, Nose.....	<input type="checkbox"/>	<input type="checkbox"/>	Neck.....	<input type="checkbox"/>	<input type="checkbox"/>	Vision	Right	Left
Mouth.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint Function.....	<input type="checkbox"/>	<input type="checkbox"/>		20/_____	20/_____
Lungs, Chest.....	<input type="checkbox"/>	<input type="checkbox"/>	Acanthosis Nigricans.....	<input type="checkbox"/>	<input type="checkbox"/>	Glasses	20/_____	20/_____
Heart.....	<input type="checkbox"/>	<input type="checkbox"/>	Spine.....	<input type="checkbox"/>	<input type="checkbox"/>	Contacts	20/_____	20/_____
Abdomen.....	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis Screening.....	Pass	Fail			

Hearing & Vision Testing Required for ALL Grades

Explain any abnormal or positive findings _____

I certify that my examination of the above student has revealed that he/she is physically able to participate in the following activities: Physical Education (all grades), Classroom of the Earth which includes camp-outs and backpacking (all grades), Athletics (Middle School Sports) including Football, Basketball, Track & Field, Volleyball, Baseball, Soccer, Softball, and Golf.

No Participation Until (set date) _____ Signature of Examining Physician _____

Telephone (____) _____ Printed Name of Physician _____