CAP CANA HERITAGE SCHOOL

MEDICAL FORM

(2026-2027)

STUDENT'S NAME:	GRADE:
MY CHILD HAS HEALTH INSURANCE: YES ( ) NO ( )	COMPANY-POLICY NO.:
NAME OF DOCTOR:	PHONE:

PHYSICAL EXAMINATION

Height _____ Weight _____ Blood type _____ Blood Pressure _____

SYSTEM REVISION:	
GENERAL:	
HEAD:	
HEART RATE:	
TORAX:	
ABDOMEN:	
GENITOURINARY:	
EXTREMITIES:	
NEUROLOGICAL:	
OTHER:	

I certify that I have examined this child and find him/her physically able to compete in any supervised activities at school.

Y ( ) N ( )

If you indicated "No," please specify any restrictions the child might have:

_____
_____
_____

E. I certify that the above named child is completely immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, hepatitis A & B and rubella. Y ( ) N ( )

CCHS is not responsible for elevated risks associated with not vaccinating.

I certify that the information offered in this document is correct and up to date. I agree to give updates to the school on a regular basis on the conditions that my child might have or requested by Cap Cana Heritage School I understand that I am required to inform the school immediately if my child has a disease or there is a change in an existing condition. I acknowledge that Cap Cana Heritage School will do its best effort in caring for the well-being of my child.

NAME OF DOCTOR_____ Exequatur _____

Office phone: _____ Cel: _____

Work address: _____

Stamp: _____ Sign _____