

**Attention: Please fill out both sides of this form and return to school in a timely manner.**



**Date of Exam:** \_\_\_\_\_

## Medical Examination Form

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Address** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_

*To be completed by Family Physician prior to student's admittance to school.*

- I.** **Blood Pressure** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Hearing Test** \_\_\_\_\_  
**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_  
**Vision (without glasses)** \_\_\_\_\_ **Vision (with glasses)** \_\_\_\_\_

**II.**

Systems Examined	Comments About Findings
- General Appearance	
- Ears	
- Eyes	
- Lymph Glands	
- Thyroid	
- Nose	
- Throat	
- Teeth-Mouth	
- Heart	
- Lungs	
- Abdomen	
- Hernia	
- Genito-urinary	
- Orthopedic: Structural	
Posture	
Feet	
- Skin	
- Nutrition	
- Nervous System	
- Speech	

**III. Behavioral Observations:** \_\_\_\_\_

**IV. History Summary:**

**A. Abnormal conditions which may require education evaluation, environmental accommodations or limits on activities:** \_\_\_\_\_

**B. Serious or chronic illnesses treated by physician:** \_\_\_\_\_

**C. Operations and/or hospitalizations:** \_\_\_\_\_

**V. Allergies: (food, medicines, insect bites-stings, other)** \_\_\_\_\_

VACCINE TYPE	1 <sup>ST</sup> Dose Mo/Day/Yr	2 <sup>ND</sup> Dose Mo/Day/Yr	3 <sup>RD</sup> Dose Mo/Day/Yr	4 <sup>TH</sup> Dose Mo/Day/Yr	5 <sup>TH</sup> Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>*(If DT or Td, indicate)</i>					
Tdap					
POLIO - INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV)</i>					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB) **					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					

REQUIRES MEDICAL EXEMPTION \*\*REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5<sup>th</sup> Birthday Only) \*\*\*Not Required

Document below single antigen vaccine receipt, serology titers, or varicella disease history		
Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

MANTOUX TEST	DATE	Results/Data
MEDICAL NOTES:		

Examining Physical (Print)

Telephone

Signature of Physician

Date