DEPARTMENT OF STUDENT SUPPORT SERVICES
OFFICE OF HEALTH SERVICES

Medical Examination Report

(Confidential Report – This report to be returned directly to the school nurse)

Attach a copy of the current immunization record which states month, day, and year of all vaccines and Tb tests received.

Date of Exam _____ ALL INFORMATION MUST BE FROM WITHIN PAST 12 MONTHS

Student's Name _____ DOB _____ Age on Exam _____
LAST FIRST MI

Height _____ Weight _____ Bp _____ Temp _____

Vision: Circle near or far tests; RT _____ LT _____ Both _____ Hearing: RT _____ LT _____

Review of systems	Normal	Abnormal – comments / recommended follow-up
Eyes		
Ears, Nose & Throat		
Teeth/Gums		
Skin		
Cardiovascular		
Respiratory		
Abdomen		
Muscular Skeletal		
Genitalia		
Mental/Behavioral		

Laboratory tests (results): Date: _____ **Hgb or Hct _____ Date: _____ UA results _____
Date: _____ **Blood lead results _____
Date: _____ **Sickle cell screen: ____ Negative ____ Sickle Trait ____ Sickle Cell Disease
Date: _____ **Tb skin test, results ____ Negative ____ Positive

** Items are required for all preschool children

Medical Conditions, complications, prescribed medications, comments, limitations, recommended follow-up (add additional pages as needed)

_____
_____
_____
_____
_____

Please check appropriate box below for this child

☐ I have examined the above mentioned child and found the child to be in good general health and capable of full participation in either an Early Childhood, Elementary, Middle, or Secondary Education program.

☐ I have examined the above mentioned child and found that due to a physical condition, the child is capable of participation in either an Early Childhood, Elementary, Middle, or Secondary Education program with some limitations.

Physician name _____ Address _____
PLEASE PRINT

Physician signature _____ Phone _____