

PRIVATE MEDICAL EXAMINATION REPORT

STUDENT _____ Date of Birth _____ Grade _____

1. IMMUNIZATIONS: (please indicate exact dates: month, day, year)

DPT/DTaP or Td	Polio:	HIB:	MMR: _____	HEP B: _____	Tuberculin Test _____
1. _____	1. _____	_____	_____	_____	Type: _____
2. _____	2. _____	_____	_____	_____	Result: _____
3. _____	3. _____	_____	Measles _____	_____	BCG: _____
4. _____	B. _____	_____	Mumps _____	Varivax: _____	Hgb: _____
5. _____	B. _____	_____	Rubella _____	Prennar: _____	Lead: _____
				_____	Other _____

Please Indicate Dates (To be completed by School Nurse)

2. PUPIL'S HEALTH HISTORY

**** CONDITIONS REQUIRING MEDICAL ATTENTION**

FAMILY HISTORY

Rheumatic Fever	_____	_____	_____
Tuberculosis	_____	_____	_____
Asthma	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Heart Disease	_____	_____	_____
Sickle Cell Anemia	_____	_____	_____
Hypertension	_____	_____	_____
Chicken Pox	_____	_____	_____
Ear Infections	_____	_____	_____
Operations	_____	_____	_____
Injuries	_____	_____	_____
Significant Allergies	_____	_____	_____
Other	_____	_____	_____

3. EXAMINATIONS

(To be completed by Physician)

Ears	_____
Eyes	_____
Nose	_____
Throat	_____
Teeth/Mouth	_____
Neck	_____
Lymph Glands	_____
Thyroid	_____
Heart	_____
Chest Contour	_____
Lungs	_____
Abdomen	_____
Hernia	_____
Genito-Urinary	_____
Orthopedic	_____
Structural	_____
Posture	_____
Feet	_____
Skin	_____
Nutrition	_____
Nervous System	_____
Speech	_____
Other	_____
General Appearance	_____
B/F	_____
Weight	_____
Height	_____

A. History of Surgery _____

B. Evidence of visual or hearing difficulty: _____

**C. Description of condition requiring attention: _____

D. Recommendations: _____

E. Restrictions: _____

Any other special recommendation to the school nurse and teacher to benefit the student's physical & emotional well-being:

Physician: _____ Address _____
 (Print or Type Name)

Date of Examination: _____