

**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 immunizations which states month, day, and year of all vaccines and available Tb tests received.***

**The following items are required for all Pre-K children**

Date of Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ALL INFORMATION MUST BE FROM WITHIN PAST 12 MONTHS**

Student’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age on Exam \_\_\_\_\_\_

 LAST FIRST MI

Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_ B/p \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temp \_\_\_\_\_\_\_\_\_\_\_

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

Laboratory tests (results): Date: \_\_\_\_\_\_\_\_\_\_\_ Hgb or Hct \_\_\_\_\_\_\_\_\_\_ **(numeric result)** Date: \_\_\_\_\_\_\_\_ UA results \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_ Blood lead results \_\_\_\_\_\_\_\_\_\_ **(numeric result)**

 **(optional)** Date: \_\_\_\_\_\_\_\_\_\_\_ Sickle cell screen: \_\_\_\_ Negative \_\_\_\_ Sickle Trait \_\_\_\_ Sickle Cell Disease

 **(optional)** Date: \_\_\_\_\_\_\_\_\_\_\_ Tb skin test, results \_\_\_\_ Negative \_\_\_\_ Positive

|  |  |  |
| --- | --- | --- |
| **Physical Exam** | **Normal** | **Abnormal – comments / recommended follow-up** |
| **Eyes** |  |  |
| **Ears, Nose & Throat** |  |  |
| **Teeth/Gums** |  |  |
| **Skin** |  |  |
| **Cardiovascular** |  |  |
| **Respiratory** |  |  |
| **Abdomen** |  |  |
| **Muscular Skeletal** |  |  |
| **Genitalia** |  |  |
| **Mental/Behavioral** |  |  |

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

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***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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OHS-13 (formerly OHS-19) 07/2004 (REV June 2019)**