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_____	Prevnar:_____	Lead:_____
				_____	Other_____

Please Indicate Dates

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		

A. History of Surgery_____

_____

B. Evidence of visual or hearing difficulty:_____

_____

**C. Description of condition requiring attention:_____

_____

D. Recommendations:_____

_____

3. EXAMINATIONS
(To be completed by Physician)

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

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:_____ _____

Signature of Physician

~ RETURN TO THE SCHOOL NURSE ~