Private Medical Examination Report

Student_____ Date of Birth_____ Grade_____

1. **Immunizations**: Please indicate exact month, day, and year

DPT or Td	Polio	HIB	MMR	Hep B	Tuberculin Test
1._____	1._____	1._____	_____	_____	Type_____
2._____	2._____	2._____	_____	_____	Result _____
3._____	3._____	3._____	Measles_____	Varicella_____	BCG_____
B._____	B._____	_____	Mumps_____	Varicella_____	
B._____	B._____	_____	Rubella_____		
Tdap_____	Menactra_____			Hep A_____	Hep A_____

PUPIL'S HEALTH HISTORY

Allergies_____
Asthma_____
Diabetes_____
Drug Sensitivities_____
Heart Disease_____
Injuries _____

**Conditions Requiring Medical Attention

Lyme's Disease_____
Mononucleosis_____
Operations_____
Otitis Media_____
Rheumatic Fever_____
Seizure Disorder_____
Other_____

* Family History

A. History of Surgery_____

_____

B. Evidence of hearing or visual difficulty_____

_____

C. Description of condition requiring attention_____

_____

D. Recommendations_____

_____

E. Restrictions_____

_____

EXAMINATION – To be completed by the physician

Ears _____
Eyes _____
Nose _____
Throat _____
Mouth _____
Neck _____
Lymph Nodes_____
Thyroid _____
Heart _____
Chest Contour_____
Lungs _____
Abdomen_____
Hernia _____
Genito-Urinary _____
Orthopedic
Scoliosis_____
Structural_____
Posture _____
Feet _____
Skin _____
Nutrition_____
Nervous System_____
Speech _____
Other _____
General Appearance_____
B/P _____
Height_____
Weight_____

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

_____

_____

Physician_____
(Print or Type Name)

Address_____

_____

Physician's Phone Number_____

Date of Examination_____

_____
(Signature of Physician)

PLEASE RETURN THE COMPLETED FORM TO THE SCHOOL NURSE