Medical Examination Record

School _____

** This form should be returned to school at registration or during the first week of school. **

Completed by Parent or Guardian:

Student's Name: _____

Parent/Guardian: _____

Address: _____ Phone: _____

Date of Birth: _____ Gender: Male _____ Female _____

Has an eye care professional ever examined your child's eyes? Yes _____ No _____

Why was the exam sought and what was the outcome? _____

Date of last dental exam: _____

**Reminder: Both a dental & vision examination are recommended prior to school entrance. **

Completed by Physician, Nurse Practitioner or Physician's Assistant:

Note to Clinician: This examination must have been completed within the one year period preceding the date of enrollment. The cost of the medical evaluation is the responsibility of the parent, legal guardian or legal custodian of the student.

Medical Conditions, Serious Illnesses or Past Hospitalizations of significance to school personnel (include allergies):
_____
_____
_____

Any physical limitations that indicate the student should restrict or not participate in outdoor play or physical education (Be specific): _____
_____

Is there evidence of or treatment for an emotional or behavioral problem? Yes _____ No _____

List medications the student takes at home or will be taking at school:
_____
_____
_____

Please indicate any school nursing intervention or consultation that is needed:
_____

Date of examination: _____ **Date of Report Completion:**_____

Clinician Signature: _____

Clinician Name and Address (Print): _____

_____ **Phone:** _____