Medical examination of students is requested in an effort to detect any health problem which could interfere with the ability to learn or to take part in all school activities including regular physical education, sports, and driver education. This record becomes an important part of the Cumulative School Health Record, helping educators to plan an appropriate program for each child.

TO PARENTS (Part A—fill out as completely as possible)

Immunization: If you have, or can get, accurate records of the dates of your child's immunizing "shots," please fill out **"immunization"** and **"booster"** columns.

Date of illness: If your child has **had the disease** (example—Measles) write "D" and the **year** after the disease.
If your child has **not had the disease or the vaccine** put "O" after the disease in **all 3 columns.**

If possible, take your child to the doctor yourself. There are questions about your child's health which you can answer best. If the doctor finds some problem, you can be told about it right away. If you cannot be present, try to send your child with someone who knows about any health problems, past or present.

*Emotional / Mental / Behavior Problems, such as:

AGGRESSIVE
WITHDRAWN
THUMB SUCKING
BED WETTING
NAIL BITING
HYPERACTIVITY
SHORT ATTENTION SPAN
NERVOUSNESS
TWITCHING, "TICS"
TANTRUMS
FREQUENT STOMACH UPSETS
FREQUENT HEADACHES
INCOORDINATION
ACTS YOUNG FOR AGE
COMPULSIONS (e.g. excessive handwashing)

**Undesirable Health Habits, such as:

IRREGULAR MEALS
FUSSY EATING
OBESITY
POOR SLEEPING
POOR TOOTH BRUSHING
UNTIDY APPEARANCE
POOR POSTURE

TO PHYSICIANS (Parts A, B, C, D)

Effort has been made to keep this form brief yet comprehensive enough to provide the information needed for adequate attention to health needs in planning a child's curriculum. If this form does not give you enough space to write the information or recommendations you wish to include regarding a child's special problem, please attach an additional sheet or mail the information in a letter to the school principal.

Your special attention to the **immunization record** will be very helpful. Physicians' records are often the only accurate ones available. Without such information on each child, it is impossible to determine the protection level in each school.

For examinations for Athletics, Driver Education, other special activities, physician may omit immunization record, **except "tetanus" data.**

PHYSICIAN'S COMMENTS

STUDENT MEDICAL EXAMINATION

Student's Full Name _____ Phone _____ Age _____ Race _____ Sex _____ Date _____

Address _____ Birth Date _____

_____ and Place _____

Father's Name _____ Mother's Name _____

County _____ School _____ Grade _____ Teacher _____

HISTORY OF IMMUNIZATIONS, DISEASES, OPERATIONS, INJURIES

A. (Instructions to Parents, Physicians, and Educators on other side)

IMMUNIZATION OR DISEASE	DATE OF ILLNESS	DATE OF IMMUNIZATION	LAST BOOSTER
DIPHTHERIA			
PERTUSSIS* (Whooping Cough)			
TETANUS			
POLIO—ORAL			
POLIO—SALK			
MEASLES (Rubeola)			
SMALLPOX			
MUMPS			
GERMAN MEASLES (Rubella)			
OTHER ( )			

	DATE	COMMENTS
CHICKENPOX		
SCARLET FEVER		
RHEUMATIC FEVER		
DIABETES		
ANEMIA (sickle cell)		
PARASITES (worms—type?)		
ALLERGY (type?)		
SEIZURES		
INJURY, FRACTURE		
OPERATION		
OTHER (specify)		

TUBERCULIN TEST (type) DATE NEGATIVE ☐, POSITIVE ☐, X-RAY?

B. PHYSICAL EXAMINATION

HEIGHT WEIGHT BLOOD PRESSURE

CHECK (✓) ONLY	IF ABNORMAL OR NEEDS FOLLOW-UP		PHYSICIAN'S COMMENTS, FINDINGS, TESTS (Space on other side)
NUTRITION			
NEUROLOGIC			
ORTHOPEDIC (includes arches)			
SKIN, SCALP			
EYES	R L		
VISUAL ACUITY	R L		HAS GLASSES? CONTACT LENSES?
COLOR VISION			
EARS	R L		
AUDITORY ACUITY	R L		HAS HEARING AID?
SPEECH			
NOSE, THROAT			
MOUTH, TEETH			
GLANDS, THYROID			
HEART, LUNGS			
ABDOMEN			
GENITALIA			

C. LABORATORY (if needed)

HEMOGLOBIN GM.; HEMATOCRIT %, URINE FECES

D. PHYSICIAN CHECK (✓) BOX:

	NO	YES	PHYSICIAN'S COMMENTS (Space on other side)
EMOTIONAL / MENTAL / BEHAVIOR PROBLEM*			
HEALTH HABITS PROBLEM**			
PHYSICAL HANDICAP—LIMITS ACTIVITY			
RESTRICTION NEEDED			
ENCOURAGE PARTICIPATION			
OTHER HANDICAP / DISABILITY			
SEIZURES			
ON MEDICATION ( )			
FOLLOW-UP RECOMMENDED			
FOLLOW-UP COMPLETED			

This student has completed the immunizations required by the state Yes ☐ No ☐ and in my opinion is free of any communicable disease and may be admitted to school. Yes ☐ No ☐

Child's Usual Physician _____ Examining Physician _____

Phone _____ Phone _____ License No. _____

In my opinion this student is ☐, is not ☐ physically qualified to participate in athletics ☐, driver education ☐,

other (specify) _____ as of _____ (date)

License No. _____ Phone _____ Examining Physician _____

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