MILWAUKEE JEWISH DAY SCHOOL

MEDICAL EXAMINATION

Student First Name: _____ Last Name:_____

To be completed by a licensed Medical Provider. This examination and the date listed below must be performed within 12 months of the first day of school. Examination for some other purpose within this period of time is acceptable. Examination for determining fitness to engage in strenuous physical activity.

Date of Exam: _____Height: _____ Weight: _____ BP: _____ DOB: _____

Please indicate yes for satisfactory and no if there are any concerns. Include explanations of negative responses, using the back of this form if necessary.

Eyes	_____	Throat	_____	Abdomen	_____
Glasses	_____	Teeth	_____	Allergy	_____
Ears	_____	Extremities	_____	Heart	_____
Nose	_____	Posture/spine	_____		
Lungs	_____	Skin	_____		

Explanations:

_____

General Appraisal:

_____

For Females:
Has this person menstruated? _____ If not, have they been told about it? _____ If so, is their menstrual history normal? _____ Special considerations _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT SCHOOL
Special diet: _____
Special medicine: _____
Strenuous activity:_____
Other: _____

I have examined the person herein described and have reviewed their health history. It is my opinion that they are physically able to engage in school activities except as noted above.
Licensed Medical Provider Signature_____ Date _____
Licensed Medical Provider Printed Name_____
Address _____ Phone _____
City, State, Zip _____