WESTLAKE City Schools

WESTLAKE EARLY CHILDHOOD PROGRAM
SCHOOL ENTRANCE MEDICAL RECORD
TAKE THIS FORM TO YOUR PHYSICIAN TO COMPLETE

Office Use:
Center Based / Itinerant
Docs_____
Case Mgr_____
Clinic _____

STUDENT NAME_____ DATE OF BIRTH_____ GENDER M / F

LAB RESULTS / IMMUNIZATION HISTORY

MONTH, DAY AND YEAR ARE REQUIRED FOR EACH OF THE FOLLOWING DATES:

****Immunization Record Must Be Attached****

Lead Poisoning	☐ Date	_____	Type	☐ C	☐ V	Results	_____ µg/dL
Hemoglobin	☐ Date	_____	Type	☐ C	☐ V	Results	µg/dL

PHYSICAL EXAMINATION

DATE OF EXAM: _____ Eyes: _____ Ears: _____

Height: _____ Vision: R: 20/ _____ Hearing: Type _____

Weight: _____ L: 20/ _____ R: _____ L: _____

Referred to ear or eye specialist? Yes _____ No _____

Nose: _____ Throat: _____

Mouth: _____ Teeth: _____

Is dental work indicated? Yes _____ No _____

If so, are plans being made? Yes _____ No _____

Posture:	_____	Abdomen:	_____	Nervous System:	_____
Skin:	_____	Genitalia:	_____	Lungs:	_____
Neck:	_____	General Condition:	_____	Hernia:	_____
Heart:	_____	Orthopedic:	_____	Urinalysis:	_____

Remarks & Recommendations: _____

Allergies (Food/Insect): _____ Recommended Treatment: _____

☐ Immunization record is attached to this form.

Physician Name (Please Print):_____ Physician Signature: _____