Madison Local School District

Student Medical Record

Fax# 440-428-9379

(To be completed by a licensed physician)

Child's Name: _____ Date of Birth: _____

Address: _____

EXAMINATION

Date: _____ Height: _____ Weight: _____

Eyes: _____ Vision – Right 20/_____ Vision – Left 20/_____

Ears: _____ Type of Hearing Test: _____ Right _____ Left _____

Referred to ear or eye specialist? No Yes

Nose: _____ Throat: _____ Mouth: _____

Teeth: _____ Is dental work indicated? No Yes

Posture: _____ Orthopedic: _____

Skin: _____ Nervous System: _____

Neck: _____ Lungs: _____

Heart: _____ Hernia: _____

Abdomen: _____ Urinalysis: _____

Genitalia: _____ General Condition: _____

Remarks & Recommendations: _____

_____

IMMUNIZATIONS

(include Month, Day & Year for each)

DPT 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Polio 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

MMR (Measles Mumps, Rubella) 1. _____ 2. _____ MMR Booster _____

Hepatitis B 1. _____ 2. _____ 3. _____ 4. _____

HIB 1. _____ 2. _____ 3. _____ 4. _____ (Pre School only)

Tuberculin Test _____ Results _____

Varicilla Vaccine (Chicken Pox) 1. _____ 2. _____

(Specify Vaccine and/or Disease Date)

Other Immunizations: _____

(Specify Dates and Types)

SCREENING TESTS – PRESCHOOL ONLY

These screenings are required by ODE Licensing Guidelines for Preschool Students.
Enter dates if done previously. Record results to assist with follow-up.

Hemoglobin Date: _____ Results: _____

Lead Date: _____ Results: _____

_____ _____

Physician's Signature Physician's Name (Please Type or Print)

_____ _____

Physician's Phone Number Physician's Address