Medical Examination for ALL Students
Form must be signed by both physician and a parent or legal guardian

Date of Examination: _____

Student's Name: _____ **Date of Birth:** _____

Grade: _____ **Height:** _____ **Weight:** _____

Significant History	Yes/ No	Physical Examination	N =normal A =abnormal
Allergy (type)		HEENT	
Asthma		Neck	
ADD/ADHD		Chest	
Diabetes		Heart	
Tuberculosis		Lungs	
Neurological		Abdomen	
Encopresis		Genitourinary	
Enuresis		Spine & Extremities	
Serious injury or illness		Integumentary	
Communicable Disease		Growth & Development	
Immunizations CURRENT		Acanthosis Nigricans	

Scoliosis Screening

Required for ALL Middle School Students.
Examination: **NORMAL** _____ **REFERRED** _____
Comments:

Are there any major health problems in the family that may affect this student in school? **YES** ____ **NO** ____
If yes, please comment:

Does this student require special assistance due to health problems or disabilities? **YES** ____ **NO** ____
If yes, please comment:

Is this student taking any medication? **YES** ____ **NO** ____
If yes, please list medication(s):

Medications to be administered at school? **YES** ____ **NO** ____
If yes, please submit Prescription Medication Form to School Nurse.

Please describe any health problems that may affect this student's participation in school. Please specify any activity restrictions.

I have examined _____ and find that he/she is **ABLE to Participate** in the complete school program, which may include physical education and team sports, unless otherwise described above.

Physician Signature

Physician Name (PLEASE PRINT)

Physician Telephone #

Parent / Guardian Signature **Date**

Parent / Guardian Telephone #