

SOUTH CENTRAL COMMUNITY SCHOOL CORPORATION

Medical Exam Form

Date of Exam: ___/___/___

Student Legal Name: _____ Date of Birth: ___/___/___ Sex: M or F

Height: _____ Weight: _____ HR: _____ BP: _____	Vision Acuity Near: Right 20 / ___ Left 20 / ___ Far: Right 20 / ___ Left 20 / ___ Glasses: ___ No ___ Yes	Hearing Acuity Right _____ Left _____	Immunizations Up to date: ___ No ___ Yes *Please attach copy
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Systems	Normal	Comments / Follow-up Needs
General appearance, posture, gait		
Speech / Language development		
Behavior during examination		
Skin		
Eyes		
Ears		
Nose, throat, glans		
Throat, tonsils, glands		
Heart		
Lungs		
Abdomen (including Hernias)		
Genitalia		
Extremities – Orthopedic		
Neurological (concussions)		
Nutrition – restrictions		
Developmental Screening		
Teeth		
Seizures		
Other		

Findings: If yes, medical action plan will be required.

Asthma: No Yes Intermittent Exercise Induced Other _____

Allergies: None Yes Drug Food Insects Other _____

Anaphylaxis: No Yes Epi-Pen Required History Describe _____

Daily Medications (specify) _____

Dietary Restrictions _____
(specify) _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect their educational experience. Explain: _____

This student may: Participate fully in the school program and athletic activities.
 Participate in the school program with the following restriction/adaptions:
 Specify: _____

Are you the students medical home/primary care provider? Yes No

Signature of Physician: _____	Date: _____
Printed/Stamped Provider Name & Phone Number: _____	

I, as parent/guardian, give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian: _____ **Date:** _____