

MEDICAL EVALUATION RECORD OF STUDENT
(with Physician's Recommendations)

Student's Name _____ Birth date _____ Sex _____ Grade _____

Father's Name _____ Mother's Name _____

- I. A. Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other? Yes No Explain: _____
- B. Does student have any other medical problems the school should be concerned with? Yes No If yes, explain: _____

II. **A. Immunization** as required by law. It is expected the physician will administer whatever inoculations are indicated at the time of this examination and record these below:

Name	Date	Date	Date	Date	Date
DPT or DT					
Polio					
MMR					
Varicella					
Hepatitis B					
HIB					
Other:					
Other:					

B. Tuberculin Test Type: _____ Date _____ Result _____ Follow-up _____

- C. Is there evident need for dental care? Yes No Explain: _____
- D. Is there a hearing defect for which the school could help compensate by seating or other action? Yes No Explain: _____
- E. 1. Has the student had a vision screening test? Yes No Date: _____
Result: _____
2. Are there ocular defects that indicate need for referral to an eye doctor? Yes No
Explain: _____
3. Are there any visual defects the school could help compensate by seating or other action? Yes No Explain: _____

III. Have there been any illnesses, accidents, operations, or congenital defects that limit the student's participation in: Classroom activities? Yes No Physical education activities? Yes No
Swimming? Yes No If so, explain: _____

IV. Is there any mental, emotional, or physical condition the student should remain under your periodic observation? Yes No If so, explain: _____
At what interval does the student need rechecks? _____

V. Physician's recommendation to the school: _____

I would like the nurse teacher to contact me regarding this student.

Date of examination: _____ Physician's Signature: _____

Office address: _____ Telephone: (_____) _____