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

Systems	Normal	Comments / Follow-up Needs
General appearance, posture, galt		
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:** _____