

Physician Information
SCHOOL ENTRANCE MEDICAL FORM

Name of Child _____ Birth Date _____
Month Day Year

Address _____

EXAMINATION

Date _____
Height _____
Eyes _____
Ears _____
Weight _____
Vision R.20/____ L.20/____
Hearing Test: Type _____ R.____ L.____
Referred to ear or eye specialist?
Yes _____ No _____

Nose _____
Mouth _____
Throat _____
Teeth _____
Is dental work indicated?
If so, are plans being made?
Yes _____ No _____
Yes _____ No _____

Posture: _____
Skin: _____
Neck _____
Heart _____
Abdomen _____
Genitalia _____
General Condition _____
Orthopedic _____
Nervous System _____
Lungs _____
Hernia _____
Urinalysis _____

Remarks and Recommendations: _____

IMMUNIZATIONS

DPT: 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____
Tdap/Td _____

POLIO : 1ST _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Hepatitis B: 1st _____ 2nd _____ 3rd _____

MMR (Measles, Mumps, Rubella): 1st _____ 2nd _____

HB: 1st _____ 2nd _____ 3rd _____ 4th _____ 5th _____

Varicella (Chicken Pox): _____ 2nd _____

Tuberculin Test: Type _____ Date _____ Pos. _____ Neg. _____

Signature of Physician _____ Date _____

Return to School Nurse