MARGARET MACE SCHOOL

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Report of Student Medical Examination

This form is to be completed by the student's "medical home" (family physician or advanced practice nurse).

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

Physician's Name:_____ Physician's Phone #_____

Medical History (Including allergies, past serious illnesses, injuries, and operations, medications, diabetes, familial disorders and current health problems):

_____
_____
_____
_____
_____

Exam Date:_____

Height: _____Weight: _____ Blood Pressure_____/_____ Pulse_____bpm

Vision:	NEAR R 20/_____ L 20/_____	FAR R 20/ _____ L 20/_____	Corrected: Contacts: Glasses:	[ ] Yes [ ] No [ ] Yes [ ] No [ ] Yes [ ] No

Hearing:	R_____	[ ] Pass [ ] Fail	L_____	[ ] Pass [ ] Fail

	Normal	Abnormal Findings	Comments
Ears (otoscopic)			
Eyes			
Lymph Glands			
Thyroid			
Nose			
Throat			
Teeth-Mouth			
Heart			

Lungs			
Abdomen			
Hernia			
Genito-Urinary			
ORTHOPEDIC			
Structural			
Posture			
Feet			
Skin			
Nutrition			
Nervous System			
Speech			
Other			
General **Appearance**			

PLEASE ATTACH IMMUNIZATION RECORD

Medications Currently in Use
Additional Observations

Are there any modifications required for full participation in school? [ ] YES [ ] NO

_____
_____
_____

PLEASE SIGN AND DATE

Examining Physician's/Provider's Signature:_____

Date:_____