Medical Examination of Student by Private Physician

Date of Exam_____

Union Springs Academy P.O. Box 524 Union Springs, NY 13160 Phone: (315) 889-7314 Fax (315) 889-7118

Student Name _____ Birth Date _____

Parent's Name _____Address: _____

1. Significant illness, accidents, operations, congenital defects, Family history

   _____
2. Significant Factors in home situation_____
3. Are there any abnormalities in any of the following systems? If yes, describe fully. Use an additional sheet if necessary.

a. Head, Ears, Nose, or Throat ☐ Yes ☐ No		e. Gastrointestinal	☐ Yes ☐ No
Hearing (R)_____ (L)_____		f. Hernia	☐ Yes ☐ No
b. Eyes ☐ Yes ☐ No		g. Genitourinary	☐ Yes ☐ No
Vision (R)_____ (L)_____		h. Musculoskeletal	☐ Yes ☐ No
c. Respiratory ☐ Yes ☐ No		i. Metabolic/Endocrine	☐ Yes ☐ No
d. Cardiovascular ☐ Yes ☐ No		j. Neuropsychiatric	☐ Yes ☐ No
Blood Pressure _____		k. Skin	☐ Yes ☐ No

l. Is there loss or seriously impaired function of any paired organ? ☐ Yes ☐ No

m. Are there any special recommendations for physical activity? (Phys Ed, Intramurals, etc) ☐ Yes ☐ No

Explain_____

n. Do you have any recommendations regarding the care of this student? ☐ Yes ☐ No

Recommendations_____

_____

o. Is the student now under treatment for any medical or emotional condition? ☐ Yes ☐ No

Explain_____

p. Is the student on any medications? ☐ Yes ☐ No Does this student have any allergies ☐ Yes ☐ No

if Yes, What medications or allergies? _____

_____

4. These immunization are required by the New York State Law or attach a copy from Dr. Office.

Vaccine	**Date**	**Date**	**Date**	**Date**	**Date**
DTaP*(5 doses)					
Tdap (1 dose)					
Polio (4 doses)					
Hepatitis B (3 Doses)					
MMR (2 doses)					
Varicella (2 doses)					
Meningococcal (2 doses)					

Physician Signature _____ Date_____