STUDENT MEDICAL EVALUATION RECORD

Complete this form if student is first time in formal education

The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.

Student's Name: _____ Birthdate ____/____/____ Gender: M F

Address: _____ Father's Name: _____

_____ Mother's Name: _____

School: _____

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN or PHYSICIAN'S ASSISTANT

A. Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, or other? Yes ☐ No ☐ Explain: _____

B. Does student have any other medical problem with which the school should be concerned? Yes ☐ No ☐
Explain: _____

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 ☐ If "Yes" Date: ____/____/____

Result: _____ If needed, has the student been referred to an eye doctor? Yes ☐ No ☐

2. Are there ocular defects that indicate need for referral to an eye doctor? Yes ☐ No ☐

Explain: _____

3. Are there any visual defects for which the school could help compensate by seating or other action? Yes ☐ No ☐

Explain: _____

Immunization as required by law. It is expected that the physician will administer whatever inoculations are indicated at the time of this examination and record these and other previous inoculations:

Year Completed (yyyy)		Date (mm/dd/yy
	Whooping Cough	
	DTaP/DTP/DT	
	Td/Tdap	
	Polio	
	Measles**M**umps**R**ubella	
	Varicella	
	Hep B	
	Other Vaccines	

Have there been any illnesses, accidents, operations, or congenital defects that limit the students' participation in:

Classroom Activities? Yes ☐ No ☐

Swimming? Yes ☐ No ☐

Physical Education Activities? Yes ☐ No ☐

If so, explain:

_____

Is there any mental, emotional, or physical condition, for which the student should remain under your periodic observation?

Yes ☐ No ☐ If so, explain: _____

At what interval does the student need rechecks? _____

Physician's recommendation to school: _____

_____

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

Date of examination: _____ Signature: _____

Office Address: _____ Phone: _____