<u>School Entrance Medical Record</u>

(TAKE THIS TO YOUR PHYSICIAN)

School ____

Name of Child___________________________________Birthdate_________________________
Mo. - Day - Year

Address____

<u>EXAMINATION</u>

Height__________________ Weight____________________ Date________________________

Eyes______________________ Vision R. 20/_____________________ L. 20/____________________

Ears_____________________________ Hearing Test: Type _________________________________

Referred to ear or eye specialist? _____________ Yes__________ No__________ R. ___________ L. _______

Nose___________________________________ Throat _____________________________________

Mouth ___________________________________ Teeth ____________________________________

Is dental work indicated? If so, are plans being made? _____________________________________

Posture________________________________ General Condition _____________________________

Skin __________________________________ Emotional ____________________________________

Neck__________________________________ Blood Pressure_________________________________

Heart__________________________________ Orthopedic____________________________________

Abdomen_______________________________ Nervous System________________________________

Genitalia_______________________________ Lungs____

Hernia_________________________________ Urinalysis____________________________________

Remarks and Recommendations____

May carry full physical education program? _____________________ Restricted?___________________

Explain____

DPT Yes______ No______ Dates: 1st_______ 2nd________3rd_________4th_______ 5th _____
(Triple Toxoid)

	OPV or IP	OPV or IPV	OPV or IPV	OPV or IPV
Polio Vaccine	1st_______	2nd______	3rd________	4th_______

MMR 1st_____ 2nd_____ Hepatitis B 1st_____ 2nd_____ 3rd_____

Chicken Pox ____________

TUBERCULIN TEST Date_________ Type__________ Results:_________________

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Signature of Physician