

# SCHOOL MEDICAL EXAMINATION FORM

All local boards of education shall require a medical examination of each child first entering school within a period of six months prior to or one month following admission to school, and have an approved program of continuous health supervision which shall include evidence of having been screened for tuberculosis in accordance with KRS 158.036 and 214.034, vision, hearing and scoliosis scheduled screening tests.

## PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

### IDENTIFYING INFORMATION

Student Name: \_\_\_\_\_ Birthday : \_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

In Emergency Call: \_\_\_\_\_ Telephone: \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Student's Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

### RECORD OF IMMUNIZATIONS TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID.230.

### MEDICAL HISTORY

Seizures: \_\_\_\_\_

Chronic Illness: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_

### Physical Exam:

N.	ABN.	Hgt. _____ Wgt. _____ BP: _____ / _____
_____	_____	Hearing: R _____ L _____
_____	_____	Vision: R _____ / _____ L _____ / _____
_____	_____	School Readiness – Normal: _____
_____	_____	Needs Evaluation: _____
_____	_____	HCT: _____
_____	_____	Optional ..... UA: _____
_____	_____	T.B. Testing Date Given: _____
_____	_____	Read: _____
_____	_____	Type _____ Induration: _____

Explain Abnormal Exam: \_\_\_\_\_

### Recommendations:

\_\_\_\_\_ No Restrictions: Normal Exam

\_\_\_\_\_ No Restrictions – Abnormal Exam – Explain: \_\_\_\_\_

\_\_\_\_\_ Special Seating Needed: YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_ Restrictions and suggestions to school: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician

Address: \_\_\_\_\_ Phone: \_\_\_\_\_