Dubuque COMMUNITY SCHOOLS

PRESCHOOL / KINDERGARTEN MEDICAL EXAMINATION

STUDENT INFORMATION

STUDENT NAME:	DATE OF BIRTH (mm/dd/yyyy):
PARENT / GUARDIAN NAME(S):	SCHOOL ATTENDING:
HEALTH CARE PROVIDER:	DATE OF EXAMINATION:

IMMUNIZATIONS

Attach a copy of the immunization record.

PERTINENT ILLNESS, COMMUNICABLE DISEASES, RISKS, OR DEVELOPMENT PROBLEMS *Please check all that apply.*

[ ] ALLERGIES *If yes, please list:*	[ ] ASTHMA	[ ] ATTENTION / LEARNING
[ ] BLEEDING DISORDER	[ ] CANCER/LEUKEMIA	[ ] CEREBRAL PALSY
[ ] CHICKEN POX *If yes, date:*	[ ] CYSTIC FIBROSIS	[ ] DENTAL PROBLEMS
[ ] DIABETES	[ ] EMOTIONAL / BEHAVIORAL	[ ] ENCOPRESIS
[ ] ENURESIS	[ ] GENETIC DISORDERS	[ ] HEART CONDITIONS
[ ] HEARING DISORDER	[ ] HEPATITIS	[ ] KIDNEY DISORDER
[ ] LEAD LEVEL *If yes, test done:* [ ] YES [ ] NO *At risk:* [ ] YES [ ] NO	[ ] OBESITY	[ ] ORTHOPEDIC CONDITION
[ ] PNEUMONIA	[ ] SEIZURE / CONVULSIONS	[ ] SICKLE CELL ANEMIA
[ ] SPEECH / LANGUAGE	[ ] TUBERCULOSIS	[ ] VISION

[ ] OTHER *If yes, please list:*

[ ] COMMENTS *If yes, please explain all that apply:*

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL
GENERAL APPEARANCE	[ ]	[ ]
HEENT	[ ]	[ ]
SKIN	[ ]	[ ]
NECK	[ ]	[ ]
CHEST	[ ]	[ ]
HEART	[ ]	[ ]
ABD/GENITALIA	[ ]	[ ]
MUSCULOSKELETAL	[ ]	[ ]
NEURO	[ ]	[ ]

HEIGHT:

WEIGHT:

BLOOD PRESSURE: /

HEARING: R L

VISION: R L

Optional:

HCT/HGB:

UA:

TB TEST *Date*:

Type: *Results:*

SUMMARY OF FINDINGS

[ ] WELL CHILD; NO CONDITIONS IDENTIFIED OF CONCERN

[ ] CONDITIONS IDENTIFIED THAT ARE OF CONCERN TO SCHOOL AND/OR PHYSICAL ACTIVITY
Complete sections below and explain here:

[ ] INDIVIDUAL HEALTH PLAN NEEDED

[ ] SPECIAL DIET REQUEST FORM

[ ] PHYSICAL EDUCATION EXCUSE

[ ] MEDICATION ORDER FORM

[ ] ASTHMA MEDICATION ORDER FORM

[ ] ALLERGY / ASTHMA ACTION PLAN

PROVIDER INFORMATION

PROVIDER'S NAME:	PHONE:	
ADDRESS:	CITY:	ZIP:

PROVIDER'S SIGNATURE

DATE

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.