

**MEDICAL REPORT**

**TO BE COMPLETED BY THE FAMILY PHYSICIAN AND RETURNED TO  
THE SCHOOL NURSE BY JUNE 1, 2005**

**STUDENT'S NAME** \_\_\_\_\_ **GRADE** \_\_\_\_\_

**IMMUNIZATIONS NOT PREVIOUSLY REPORT:**      **LABORATORY TESTS  
DONE:**

\_\_\_\_\_

\_\_\_\_\_

**RECORD OF PHYSICAL EXAMINATION:**

**HEIGHT** \_\_\_\_\_ **WEIGHT** \_\_\_\_\_ **BLOOD PRESSURE** \_\_\_\_\_ **PULSE** \_\_\_\_\_

**SKIN AND SCALP** \_\_\_\_\_ **ABDOMEN** \_\_\_\_\_

**NOSE AND THROAT** \_\_\_\_\_ **HERNIA** \_\_\_\_\_

**LUNGS** \_\_\_\_\_ **GENITALS** \_\_\_\_\_

**HEART (Any irregularity? If yes, please explain)**

\_\_\_\_\_

\_\_\_\_\_

**ORTHOPEDIC DEFECTS, e.g.,      SCOLIOSIS:      YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**ANY TREATMENT NECESSARY?** \_\_\_\_\_

\_\_\_\_\_

**ARE ANY MEDICATIONS BEING TAKEN BY THE STUDENT?**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_ **IF YES, PLEASE SPECIFY:** \_\_\_\_\_

\_\_\_\_\_

**GENERAL CONDITION OF THE STUDENT** \_\_\_\_\_

\_\_\_\_\_

**ARE THERE ANY HEALTH FINDINGS WHICH MIGHT HAVE AN EFFECT  
ON THE EDUCATIONAL MANAGEMENT OF THE STUDENT? IF YES,  
PLEASE EXPLAIN:** \_\_\_\_\_

**IN YOUR OPINION, IS THE PUPIL CAPABLE OF CARRYING A FULL  
PROGRAM IN PHYSICAL EDUCATION AND SPORTS?      YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**IF NO, PLEASE**

**EXPLAIN:** \_\_\_\_\_

\_\_\_\_\_

**SIGNATURE OF PHYSICIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

rptmed