

Report of Medical Examination

*This page needs to be filled out by a **PHYSICIAN**.

Student's Name: Last _____, First _____ Middle _____

Date of Birth (mm/dd/yr): ____/____/____ Grade/Year _____

Height _____ cm	Weight _____ kg	Blood Pressure ____/____ (ONLY for students age 11 and older)	Pulse _____
Vision: R _____ L _____		Both _____ Corrective Lens: <input type="checkbox"/> Yes / <input type="checkbox"/> No	

NOTE: Please administer the following REQUIRED tests.	Date (mm/dd/yr)	Result
Tuberculosis Skin Test OR Chest X-ray OR TB blood test (IGRA) (NOTE: If TB skin test result is positive, either chest X-ray or TB blood test (IGRA) is required regardless of previous BCG vaccination.)		TB skin test: Chest X-ray: TB blood test (IGRA):
Hemoglobin (Students under 5 years of age are exempt from this test.)		
Urinalysis (Students under 3 years of age are exempt from this test.)		

	Normal	Abnormal		Normal	Abnormal
Ears/Hearing			Musculoskeletal		
Nose			Spine		
Mouth			Skin		
Throat			Neurological		
Neck			Nutritional		
Heart			Emotional/Psychological		
Lungs			Behavior		
Abdomen			Speech		

Physician's Comments:

Please list any medication the student takes on a regular basis.
NOTE: A separate medical form (Part III) is required for all medication and treatment to be administered at school.

Name of Medication	Purpose	Dose/Time

» This student is physically able to participate in all physical education and sports activities: Yes / No

If NO, please explain:

NOTE TO THE PHYSICIAN: SFS follows the [U.S. CDC immunization schedule](#). Please help us ensure this student's vaccinations are up to date and he/she has received booster vaccinations of DTaP, Polio & MMR at age 4-6 and DT/Td/Tdap at age 11-12. Immunization record is on a separate form (Part I - 3). If immunization is administered, please complete the form. Thank you.

** Please note that SFS does NOT accept a student's physical exam certified by a parent who may be a physician or medical professional.*

Physician Signature	Date of Examination (mm/dd/yr)
Printed Name	Clinic Name & Phone Number