Lawrence Public Schools
Medical Examination Form (Elementary)

Name_________________________________ **Sex: M**_____ **F**_____

Birthdate___________________

PHYSICAL EXAMINATION: To be completed by physician or nurse approved to do health assessment.

Height ______________ Weight_____________ BP_________ HR__________ Hbg or HCT_________

Head_______________ Lungs_____________ CNS________ Skin_________ EENT_____________

Breast______________ Dental_____________ G.U./GYN ____________

Abdomen________________ Lymphatics_____________ Cardiovascular _____________

Musculoskeletal/Scoliosis _____________

SCREENING RESULTS:

Development (type of test)____

Hearing screening: Right ear _______________ Left ear _______________

Vision screening: Right eye _______________ Left eye _______________

Further evaluation of any of the above indicated? _____________________________________

School recommendations or accommodation indicated?

____

Immunizations given today:

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SIGNIFICANT ASSESSMENT FINDINGS:

COMMENTS AND RECOMMENDATIONS: Please note any special accommodations, needs, limitations or restrictions necessary for the school setting. This would include any condition that could result in a classroom emergency, such as seizures, diabetes, asthma, etc. Also note any continuous therapy or medical treatments that could affect the student's school program.

__________________ ____

Date of exam Signature of licensed physician or nurse approved to perform health assessments.

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Printed name of examiner