



# School Entrance Physician's Report

(to be completed by Doctor)

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Exam Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: R: 20/\_\_\_\_\_ L: 20/\_\_\_\_\_ Referred to eye specialist? Yes \_\_\_\_\_ No \_\_\_\_\_

Hearing test: R: \_\_\_\_\_ L: \_\_\_\_\_ Referred to ear specialist? Yes \_\_\_\_\_ No \_\_\_\_\_

Examined	WNL	Comments/Concerns	Examined	WNL	Comments/Concerns
Eyes			Ears		
Nose			Throat		
Mouth			Teeth		
Posture			Orthopedic		
Skin			Neurological		
Neck			Lungs		
Heart			Hernia		
Abdomen			Urinalysis		
Genitalia			General Condition		

Remarks and Recommendations: \_\_\_\_\_

Does student have a medical condition that the school staff should be alerted to? \_\_\_\_\_

Is this student on any medications? If yes, indicate name, dosage, and purpose: \_\_\_\_\_

(If student requires medications/treatments during school hours, a special consent form is required.)

Does student have allergies to the following: (medication, animals, insects, food, plants) ? \_\_\_\_\_

What is the students reaction to the allergies? (rash, vomiting, difficulty breathing) \_\_\_\_\_

Is this child able to participate fully in the following?  
 a. Classroom and academic activities Yes \_\_\_\_\_ No \_\_\_\_\_  
 b. Physical education activities (& swimming) Yes \_\_\_\_\_ No \_\_\_\_\_  
 c. Regular diet Yes \_\_\_\_\_ No \_\_\_\_\_

Limitations: \_\_\_\_\_

Based upon this student's medical history and physical condition at the time of this examination, he/she is free of communicable disease and is in suitable condition for enrollment in school. Yes \_\_\_\_\_ No \_\_\_\_\_

Printed name of physician \_\_\_\_\_ Signature of physician \_\_\_\_\_

Address of Physician: \_\_\_\_\_

Phone of physician \_\_\_\_\_ Date \_\_\_\_\_