

SCHOOL ENTRANCE MEDICAL EXAM

Saint Bernadette School

Name of Child _____ Birthdate _____
Complete Address _____
Parents/Guardian Name _____ Home Telephone _____
Name of Physician _____ Physician Phone _____
Name of Dentist _____ Dentist Phone _____

MEDICAL HISTORY OF CHILD

Chicken Pox _____ Mumps _____ Measles _____
Bee Sting Allergy _____ Describe reaction _____
Eczema _____ Hives _____ Epilepsy _____
Asthma _____
Any known allergies _____
Medications (list) _____
Surgical Procedures _____
Other significant Health information _____

HEALTH PROTECTIVE MEASURES

Tuberculin Test: Date: _____ Type _____ Positive _____ Negative _____

Please include month, date and year for the following:

DTaP/DTP/DT/Td:

1st _____
2nd _____
3rd _____
4th _____
5th _____

Polio Vaccine:

1st _____
2nd _____
3rd _____
4th _____

Tdap booster required for entrance to 7th grade: _____

(MCV4) Meningococcal one (1) dose required for entrance to 7th grade: _____

MMR Vaccine: 1st (received on or after 1st birthday) → 2nd (received at least 28 days after first dose)

Hepatitis B: 1st dose _____ 2nd dose _____ 3rd dose _____

Varicella-Chicken Pox: (required) 1st dose _____ 2nd dose _____
HIB Vaccine: (not a requirement) _____

MEDICAL EXAMINATION OF CHILD

Height: _____ Weight: _____
Eyes: _____ Vision: R: 20/ _____ L: 20/ _____
Ears: _____ Hearing Test: Type _____ R L _____
Any vision, speech or hearing difficulty: _____
Nose: _____ Throat: _____
Mouth: _____ Teeth: _____
Posture: _____ General Condition: _____
Skin: _____ Orthopedic: _____
Neck: _____ Nervous System: _____
Heart: _____ Lungs: _____
Abdomen: _____ Hernia: _____
Genitalia: _____ Urinalysis: _____

Remarks and/or recommendations: _____

Date: _____ 20 _____

Signature of Physician _____

Signature of Parent/Guardian _____