



Medical Report For School Entry

Child's Name _____ Birthdate _____

Address _____ City/State/Zip _____

Parent's Name(s) _____ Phone _____

Physician's Name _____ Phone _____

Medication Record:

Does your child have a medical condition that requires regular doses of prescription medication?

Yes _____ No _____

Medical Condition _____ Medication _____

If your child will need to take medication during school hours, please request the appropriate forms from the school office.

Examination Report: (To be completed by physician)

1. Is there any medical reason for limiting participation in academic work?
Yes _____ No _____

2. Is there any medical reason for limiting participation in physical education or sports?
Yes _____ No _____

3. Does the child have any known abnormalities of vision or hearing?
Yes _____ No _____

4. Do you feel that the child requires special seating due to hearing or vision loss?
Yes _____ No _____

5. Has the child ever had an allergic reaction (i.e., bee stings, food) that required emergency care?
Yes _____ No _____

6. Does the student have any chronic or long-term physical and/or emotional conditions?
Yes _____ No _____

7. Posture/Scoliosis Screening:
Normal _____ Abnormal _____

Physician's signature _____ Date _____

8. Are this child's immunizations up to date? Yes _____ No _____
(Parent is required to provide up-to-date certification of immunization status to the school prior to attendance)