Medical Forms

Name: _____ Grade: _____ Birth Date: _____

IF YOUR CHILD IS A NEW STUDENT, FILL IN ALL IMMUNIZATIONS BELOW
(IF YOUR CHILD IS A RETURNING STUDENT, FILL IN "ONLY" NEW IMMUNIZATIONS RECEIVED DURING THE PAST YEAR)

DATES OF IMMUNIZATION

	Mo.	Day	Year		Mo	Day	Year		Mo	Day	Year
DTP-1				POLIO-1				MMR-1			
DTP-2				POLIO-2				MMR-2			
DTP-3				POLIO-3				MEASLES			
DTP-4				POLIO-4				MUMPS			
DTP-5				POLIO-5				RUBELLA			
TD-1				HEP B-1				HIB-1			
TD-2				HEP B-2				HIB-2			
TD-3				HEP B-3				TB			

HEALTH EXAMINATIONS ARE REQUIRED FOR ALL KINDERGARDEN STUDENTS. THEY ARE RECOMMENDED FOR ALL NEW STUDENTS AND FOR ALL 4th, 7th, and 10th GRADE STUDENTS.

VISION: Without glasses R 20 _____ L 20 _____ with glasses R 20 _____ L 20 _____

HEARING: Right _____ Left _____ LAB _____ U/A _____ PPD _____

PHYSICAL EXAMINATION:

Height _____ Weight _____ Pulse Rate _____ Blood Pressure _____

Head _____ Eyes _____

ENT _____ Mouth and Teeth _____

Neck & Soft Tissues _____ Chest _____

Heart _____ Lungs _____

Abdomen _____ Genitalia _____

Hernias _____ Neurological _____

Skin _____ Back & Spine _____

Joints _____ Maturity Index _____

PHYSICAL EDUCATION PARTICIPATION RECOMMENDATIONS

☐ There were no history or physical findings on this exam which would prohibit this student from participating in Physicial Education.

☐ Based on this history and physical exam, the following abnormalities were found and may need treatment.

_____

_____

_____ _____

(Physician Signature) (Date)

(2/98) R-21R

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH

☐ ARE ☐ ARE NOT SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ☐ YES ☐ NO

IF YES, EXPLAIN IN SECTION IV.

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____ DPT/DT/DTAP						
_____ Polio						
_____ Hepatitis B						
_____ Hib						
_____ MMR						
_____ Varicella						

IV. COMMENTS/RECOMMENDATIONS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN ►	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )