

REPORT OF MEDICAL EXAMINATION

To the Physician:

Please use the following code to conform with the regulation of New York State Permanent School Health Record.

N or blank = No defect

XX = Defect to be treated @ later date

I = Irremedial defect

X =Possible defect under observation

XXX= Defect requiring immediate treatment

CHILD'S NAME _____

DATE _____

Height _____ Weight _____ BMI _____ GRADE _____ DOB _____ Gender: M ___ F ___

Weight Status Category:

Less than 5th _____ 85th thru 94th _____

5th thru 49th _____ 95th thru 98th _____

50th thru 84th _____ 99th and above _____

Specify Current Diseases: (check all that apply)

Asthma _____ Diabetes Type 1 _____

Hypertension(High BP) _____ Diabetes Type 2 _____

Hyperlipidemia(High Cholesterol/Triglycerides) _____

Eyes (other than vision) _____

Seizure Disorder _____

Vision: Near R ___ L ___ Distance R ___ L ___

Nervous System _____

Color _____ Muscle Balance _____

Speech _____

Ears(other than hearing) _____

Nutrition _____

Hearing: Sweepcheck R _____ L _____

Lymph Nodes _____

Immunizations and tests during past year:

Thyroid _____

Nose _____

Teeth _____

Recommendations for follow-up: _____

Heart _____

Blood pressure _____

Pulse _____

Recommendation for modification of school program,

Lungs _____

including physical education: _____

Hernia _____

Genito-Urinary _____

Orthopedic-Structural _____

Skin(non-com) _____

Scoliosis Screening _____

Posture _____

Other _____

Feet _____

Physician's Signature (Duly licensed to practice in NYS)

Physician's Name (PRINTED)

