PART B

MEDICAL EXAMINATION REPORT

To be completed by a physician or family nurse practitioner

Please give details of finding and verifying immunization history

STUDENT'S NAME: ____

DATE OF BIRTH: _______________________________AGE: _______________

HEIGHT: _________________cm WEIGHT:_______________kg BP: _________

MENARCHE: YES ( ) NO ( ) If yes, LMP_______________________

General Appearance:

____ Nutritional state:

_________________________________ Posture:

SKIN: ____________________________ TEETH/GUMS____________________

EYES: ___________________________ VISION: R L

(Indicate whether tested with glasses or not)

EARS:________________________HEARING: __________________________

NOSE/THROAT: ____

THYROID: ____

RESPIRATORY SYSTEM: ____

CARDIOVASCULAR SYSTEM: ____

ABDOMEN/BI SYSTEM: ____

CENTRAL NERVOUS SYSTEM: ____

BONES AND JOINTS: ____

DEFORMITIES/DISABILITIES: ____

GENITO URINARY SYSTEM: ____

URINALYSIS PROTEIN:_________________________

SUGAR_____________________

OTHER INVESTIGATIONS INDICATED: ____________________________________

(Follow up report to be provided)
Immunization History: Please indicate date vaccines received.

DOSES

DOSES					
Vaccine	1st	2nd	3rd	Booster 1	Booster 2
BCG					
DPT/DT					
MMR					
Chicken pox					
Hep. B					

Hib.					
Pneumovax					
Other					
Other					

- Please provide a copy of the Immunization Card for the school records

COMMENTS:

REMARKS AND RECOMMENDATIONS:

PHYSICAL ACTIVITY: UNRESTRICTED ( )

AS TOLERATED ( )

LIMITED ( )

If limited, reason: ____

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______________________ ______________________

DOCTOR'S SIGNATURE ADDRESS

DOCTOR’S NAME (WRITTEN) MCJ REG# DATE