NORTH CEDAR COMMUNITY SCHOOL DISTRICT HEALTH SERVICES
MEDICAL EXAMINATION FORM

Student's Name_____**DOB**_____

Parent/Guardian_____**School**_____

Date of Examination_____ **Health Care Provider**_____

Immunizations- Attach a copy of the immunization record.

Pertinent Illness, Communicable Diseases, Risks or Development Problems: (Please check all that apply)

___ Allergies, if so list_____
___ Epi Pen required for allergy
___ Bleeding disorder
___ Chicken Pox, if yes, date _____
___ Diabetes
___ Enuresis
___ Hearing Disorder
___ Speech/Language
___ Pneumonia

___Asthma
___ Cancer/Leukemia
___ Cystic Fibrosis
___ Emotional/Behavioral
___ Genetic Disorders
___ Hepatitis
___ Obesity
___ Seizure/Convulsions
___ Tuberculosis

___ Attention/Learning
___ Cerebral Palsy
___ Dental Problems
___ Encopresis
___ Heart Conditions
___ Kidney Disorder
___ Orthopedic Condition
___ Sickle Cell Anemia
___ Vision

___ Other _____

COMMENTS: (Please explain all that apply)_____

_____

_____

PHYSICAL EXAMINATION:

Normal	**Abnormal**	
_____	_____ General appearance	Ht_____ Wt_____ BP_____/_____
_____	_____HEENT	Hearing: R_____ L_____
_____	_____ Skin	Vision: R_____ L_____
_____	_____ Neck	Optional: HCT/HGB _____
_____	_____ Chest	Optional: UA_____
_____	_____ Heart	**House File 158 of Iowa law mandates that each child be screened**
_____	_____ Abd/Genitalia	**for lead level before entering Kindergarten.**
_____	_____ Musculoskeletal	Was this child tested for lead? Yes____No____
_____	_____Neuro	Date of Screening:_____ Result of screening_____

SUMMARY OF FINDINGS:

_____ Well child; no conditions identified of concern
_____ Conditions identified that are of concern to school and/or physical activity (complete sections below and explain here):__

_____

_____

____ Individual Health Plan needed
____ Medication Order Form
____ Special Diet Request Form
____ Asthma Medication Order Form
____ Physical Education Excuse
____ Allergy/Asthma Action Plan

Provider Signature:_____ Date:_____

Address:_____Phone:_____