# MAGNOLIA PUBLIC SCHOOLS

## *TO BE COMPLETED BY HEALTH CARE PROVIDER*

**STUDENT NAME:** _____ **DOB**: _____ **GRADE:** _____

**RECORD OF PHYSICAL EXAMINATION: (report any significant findings)**

**MEDICAL HISTORY:**

Communicable Diseases (types/years):_____

Operations (types/dates): _____ Fractures (sites/dates): _____

Heart Murmur/other Cardiac Abnormalities: _____Spinal Deformities (Scoliosis):_____

Vision/Hearing Difficulties (specify): _____

Allergies (specify): _____

Chronic Illness: _____List Medications for Chronic Illness/Allergy: _____

**SYSTEMS REVIEW:**

Height: _____ Weight:_____ Blood Pressure: _____

Vision Screening: R_____ L_____ **with correction: glasses/contacts**

Hearing Screening: R_____ L_____ with **hearing aid: right/left/both**

Ears (otoscopic) _____ Teeth/Mouth_____ Genito-Urinary _____ Nutrition _____ Eyes _____ Heart _____

Orthopedic: Structural _____ Nervous _____ Lymph Glands _____ Lungs _____ Posture_____ Feet _____

System: Thyroid _____ Abdomen _____ Speech _____ Nose _____ Hernia _____ Skin _____ Other _____

General Appearance: _____ Discuss Abnormal Findings: _____

**IMMUNIZATION RECORD: (month/day/year - all inoculations - primary/boosters)**

DT/Td, DTP, DTaP, Tdap (Indicate Type)

(1) _____ (2) _____ (3) _____

Boosters (4) _____ (5) _____

OPV or IPV (Indicate type) (1) _____ (2) _____

(3) _____

Boosters (4) _____ (5) _____

MMR (1) _____ (2) _____

Measles _____ Mumps _____ Rubella_____

Hib (1) _____ (2) _____ (3) _____ (4) _____

HepB (1) _____ (2) _____ (3) _____

HepA (1) _____ (2) _____

Varicella (1) _____ (2) _____

Pneumococcal (1) _____ (2) _____

(3) _____ (4) _____

Meningococcal (1) _____Influenza (1) _____ee

Lead Screening:Date _____ Results _____

Tuberculin Tests (type/result): _____

**SUMMARY/RECOMMENDATIONS:** (If necessary use reverse side of form)

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**Date Of Exam** _____ **Health Care Provider's Signature** (Stamp not accepted) _____