

David C. Douglass Veterans Memorial School
 2600 Bayshore Road
 Villas, New Jersey 08251
 (609) 884-9430 - MAIN OFFICE

Report of Student Medical Examination

Grades Preschool through Grade 6

This form is to be completed by the student's "medical home" (family physician or advanced practice nurse.)

Student Name: _____ Grade: _____ Age: _____ Sex: _____ Date of Birth: _____

Examination Date: _____ Physician's Name: _____ Physician's Phone: _____

Medical History (include allergies, past serious illnesses, injuries and operations, medications, diabetes, familial disorders and current health problems):

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Current Status:

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm

Vision:	NEAR	FAR	Corrected: <input type="checkbox"/> Yes <input type="checkbox"/> No
	R 20/_____	R 20/_____	Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No
	L 20/_____	L 20/_____	Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No

Hearing:	R _____	<input type="checkbox"/> Pass	L _____	<input type="checkbox"/> Pass
		<input type="checkbox"/> Fail		<input type="checkbox"/> Fail

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose			
Throat			
Teeth-Mouth			
Heart: <i>Murmurs/Rhythms</i>			
Lungs <i>Auscultation/Percussion</i>			
Chest Contour			
Skin			
Abdomen Assessment <i>(including liver, spleen)</i>			
Tanner Stage <i>Testes/Onset of Menses</i>			

Student's Name

	Normal	Abnormal Findings	Comments
Hernia			
Neck/Back/Spine <i>(Range of Motion)</i>			
Scoliosis			
Upper Extremities			
Lower Extremities			

Neurological: Balance and Coordination

▪ Romberg			
▪ Heel Walk			
▪ Tandem Walk			
▪ Nose Touch			
▪ Toe Walk			

Most Recent Immunizations/Dates

DTaP	<input type="text"/>	MMR	<input type="text"/>	Varicella	<input type="text"/>
IPV/OPV	<input type="text"/>	Hib	<input type="text"/>	Hepatitis B	<input type="text"/>
Influenza	<input type="text"/>	PCV7	<input type="text"/>	Meningococcal	<input type="text"/>

Medications Currently in Use

Additional Observations

Are there any modifications required for full participation in school? YES NO If yes, please explain below:

Family Physician/Provider YES NO School Physician YES NO

____ MD ____ DO ____ NP ____ PA

Examining Physician's/Provider's Signature: _____

Date: _____