PRE-SCHOOL MEDICAL EXAMINATION

CHIPPEWA FALLS PUBLIC SCHOOLS

PART I

Child's Name ..... Sex, M F (circle) Birth Date .....

Address ..... Parent ..... Tel. No. .....

Physician ..... Dentist .....

CIRCLE THE FOLLOWING ITEMS YOU KNOW YOUR CHILD HAS DEFINITELY HAD:

Seizures - Convulsions - Serious Illness - Surgery - Head Injuries - Serious Injuries

Chicken pox - Rheumatic Fever - Strep Infection - EXPLAIN .....

.....

Immunizations:

	Date — 1st	2nd	3rd	4th	5th
DPT	.....	.....	.....	.....	.....
Polio	.....	.....	.....	.....	.....
MMR	.....	.....			
HBV	.....	.....	.....		
HIB	.....	.....	.....	.....	
Varicella	.....	.....			

Allergies (circle) Penicillin - Sulfa - Hay Fever - Other .....

PART II **PHYSICIAN** **CIRCLE WHERE APPLICABLE**

Height ..... Weight .....

LAB TESTS RECOMMENDED: URINALYSIS ..... BLOOD .....

MEDICAL CONDITION(S) TO BE AWARE OF .....

Suspected Disability None...Cognitive, orthopedic, vision, hearing, learning, behavior

General Appearance	Healthy . . .Needs Further Evaluation			
Skin	Clear . . . Lesions			
Ears	Normal . . . Abnormal . . . Hearing Loss	Hearing	Right	Left . . . . .
Eyes	Grossly Normal . . . Abnormal	Vision	Right	Left . . . . .
Tonsils	Normal . . . Abnormal . . . Absent			
Neck	Normal . . . Abnormal			
Heart	Normal . . . Abnormal . . . Physiological Murmur			
Lungs	Clear . . . Abnormal			
Abdomen	Normal . . . Abnormal . . . Hernia			
Extremities	Normal . . . Abnormal . . . Deformities . . . Limit Activity . . .			
Neurological	Normal . . . Abnormal			
Spine	Straight . . . Scoliosed			

RECOMMENDATIONS: (CHECK)

_____ None

_____ Evaluation by School Diagnostic Study Team

_____ Other .....

IMMUNIZATIONS GIVEN AT TIME OF EXAMINATION SHOULD BE RECORDED ABOVE IN APPROPRIATE COLUMN

DATE: ..... SIGNED ..... M.D.