MEDICAL EXAMINATION REPORT

This form must be completed by a health care professional after examination of the student and returned to Scattergood Friends School: 1951 Delta Ave. / West Branch, IA 52358.

Name of Student: ______________________________ Date of Birth: __________________

Address: ____
(Street) (City) (State & Zip) (Country)

Right Eye: __________________/20 vision Left Eye: __________________/20 vision

Height: __________________

Weight: __________________ Normal Weight: __________________

Tuberculin Test: ________________________

Urinalysis: ________________________

Heart: ________________________ Blood Pressure: __________________

Lungs: ________________________

Tonsils: ________________________ Adenoids: ________________________

Athlete's Foot: ________________________ Plantar's Warts: __________________

Asthma: ________________________ Allergies: ________________________

Muscle Development: Good______________ Moderate__________ Poor________

Condition of Skin: ____

Hernia: ________________________ Thyroid: ________________________

Sinus Trouble: ________________________

Condition of Teeth: ________________________ Condition of Gums: __________________

Is there any existing condition which will require treatment while the student is at school? ___________

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Is there any reason why the student should not take part in a normal program of physical education?____

____

PLEASE COMPLETE REVERSE SIDE

Name of Student ____

PHYSICIAN INFORMATION:

Physician's Name (please print): ____

Address: ____

Phone: ____

Physician's Signature:_____________________________________ Date: __________________

3/05