

# Medical Examination

This form is to be completed and signed by the student's physician, pediatrician or nurse practitioner.  
For admission to Atholton Adventist School, every new student and every student entering First Grade, Fourth Grade, and Seventh Grade must complete this form.

Name: \_\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_

City, St. Zip \_\_\_\_\_ Grade \_\_\_\_\_

Name of School \_\_\_\_\_

Name of Doctor \_\_\_\_\_

Date of examination \_\_\_\_\_

Is there any evidence of concern in the areas listed below?

Health Area	Yes	No	Comments (please complete if "Yes")
Vision			
Hearing			
Speech/Language			
Physical illness or impairment			
Mental or emotional problems			
Development			
Allergies			
Nutrition			
Other			

Has student received a smallpox immunization?      Yes    No      If "yes", date: \_\_\_\_\_

Are there medical reasons for this child to be exempted from any of the above immunizations?    Yes    No

If "Yes" explain \_\_\_\_\_

Results of Tuberculin test (circle one)    Pos.    Neg.      Type of test: \_\_\_\_\_

Explain any Pos. results. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. Is child subject to conditions that may cause classroom emergencies such as diabetes, fainting, allergies, asthma, etc.? Yes No

Explain \_\_\_\_\_

2. Have there been any illnesses, accidents operations, or defects that limit this child's participation in classroom activities or PE? Yes No

Explain \_\_\_\_\_

3. Are there any vision or hearing defects for which the school could help compensate by seating or other action? Yes No

Explain \_\_\_\_\_

4. Are there any other defects for which the school could help by seating, or other action? Yes No

Explain \_\_\_\_\_

5. Is there evident need for dental care? Yes No

Explain \_\_\_\_\_

6. Is there any reason for which this child should remain under a Physician's periodic observation? Yes No

Explain \_\_\_\_\_

\_\_\_\_\_

7. Physician's recommendations to school: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Name of Doctor's Office or Clinic: \_\_\_\_\_

Office Address: \_\_\_\_\_  
Street city state zip

Phone number: \_\_\_\_\_