West Liberty Community School District

School Medical Report

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B.\_\_\_\_\_\_\_\_\_ M/F Grade\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAMINATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | √ = normal |  | √ = normal |  | √ = normal |
| Appearance |  | Ears |  | Hernia |  |
| Posture |  | Nose |  | Back |  |
| Nutrition |  | Throat |  | Extremities |  |
| Development |  | Lymph nodes |  | Blood Pressure |  |
| Neurological |  | Thyroid |  | Eyes |  |
| Speech |  | Heart |  | Visual Acuity |  |
| Skin |  | Lungs |  | Height |  |
| Hair/Scalp |  | Abdomen |  | Weight |  |
| Eyes/Vision |  | Genitalia |  | Teeth/Dentition |  |

**PLEASE ATTACH A LIST OF CURRENT IMMUNIZATIONS**

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lead Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Comments and Recommendations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_ Reviewed 5/19 AS/KM

Distrito Escolar de la Comunidad de West Liberty

Informe médico de la escuela

Nombre \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha de Nacimiento.\_\_\_\_\_\_\_\_\_ M/F Grado\_\_\_\_\_\_\_\_\_\_\_\_

Padre/Tutor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXAMEN FISICO**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | √ = normal |  | √ = normal |  | √ = normal |
| Appearance |  | Oidos |  | Hernia |  |
| Postura |  | Nariz |  | Espalda |  |
| Nutrición |  | Garganta |  | Extremidades |  |
| Desarrollo |  | G anglios linfaticos |  | Presión sanguínea |  |
| Neurológica |  | Tiroides |  | Ojos |  |
| Habla |  | Corazón |  | Agudeza visual |  |
| Piel |  | Pulmones |  | Altura |  |
| Pelo / cuero cabelludo |  | Abdomen |  | Peso |  |
| Ojos / Visión |  | Genitales |  | Otros |  |

**POR FAVOR ADJUNTE UNA LISTA DE VACUNAS ACTUALES**

Alergias: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicamentos:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enfermedad crónica:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cirugías / Hospitalizaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comentarios y recomendaciones del médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Firma del médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha del examen:\_\_\_\_\_\_\_\_\_\_\_\_\_ Revisado 5/19 AS/KM