SOLON SCHOOLS

STUDENT MEDICAL RECORD

(to be completed by physician)

Child's Name _____ Birth Date _____

Address _____

EXAMINATION

Date _____ Height _____ Weight _____
Eyes _____ Vision - R. 20/_____ L. 20/_____
Ears _____ Type of Hearing Test _____ R. _____ L. _____
Referred to ear or eye specialist? Yes _____ No _____
Nose _____ Throat _____
Mouth _____ Teeth _____
Is dental work indicated? Yes _____ No _____
Posture _____ Orthopedic _____
Skin _____ Nervous System _____
Neck _____ Lungs _____
Heart _____ Hernia _____
Abdomen _____ Urinalysis _____
Genitalia _____ General Condition _____

Remarks & recommendations: _____

IMMUNIZATIONS

(include month, day, year for each)

DPT 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

POLIO 1) _____ 2) _____ 3) _____ 4) _____ 5) _____

MMR (Measles, Mumps, Rubella) _____ MMR Booster _____

Hepatitis B 1) _____ 2) _____ 3) _____

HIB 1) _____ 2) _____ 3) _____ 4) _____

Tuberculin Test _____ Results _____ Chicken Pox _____
(Specify disease or vaccine)

Varicella 1) _____ 2) _____

Other Immunizations _____
(specify dates and types)

_____ _____
Physician's Signature Physician's Name (please print)

_____ _____
Phone Number Address

(1/13)