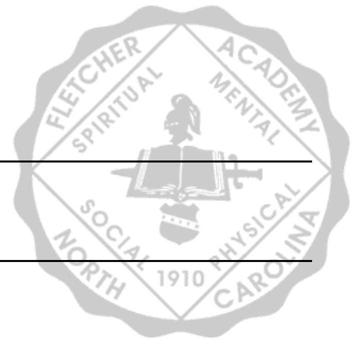
Medical Examination of Student by Private Physician

Fletcher Academy



Student Name ____________________ Birth Date ____________________

Parent's Name ____________________

Address ____

Date of Examination ____________________

1. Significant illness, accidents, operations, congenital defects, family history, etc.____________________

2. Significant factors in home situation ____________________

3. Are there abnormalities in any of the following systems? If yes, describe fully. Use an additional sheet if necessary.

a. Head, Ears, Nose, or Throat ❑ Yes ❑No
   Hearing (R) __________ (L)__________
b. Eyes ❑ Yes ❑No
   Vision (R) __________ (L)__________
c. Respiratory ❑ Yes ❑No
d. Cardiovascular ❑ Yes ❑No
   Blood Pressure __________
e. Gastrointestinal ❑ Yes ❑No
f. Hernia ❑ Yes ❑No
g. Genitourinary ❑ Yes ❑No
h. Musculoskeletal ❑ Yes ❑No
i. Metabolic/Endocrine ❑ Yes ❑No
j. Neuropsychiatric ❑ Yes ❑No
k. Skin ❑ Yes ❑No

l. Is there loss or seriously impaired function of any paired organ? ❑ Yes ❑No

m. Are there any special recommendations for physical activity (Phys. Ed., Intramurals, etc.) ❑ Yes ❑No

Explain ____________________

n. Do you have any recommendations regarding the care of this student? ❑ Yes ❑No

Recommendations ____________________

o. Is the student now under treatment for any medical or emotional condition? ❑ Yes ❑No

Explain ____________________

p. Is the student on any medications? ❑ Yes ❑No Does the student have any allergies ❑ Yes ❑No

If yes, what medications or allergies? ____________________

5. Have you ever had chicken pox? ___Yes ____No If not, have you had the VZV vaccine?______When?_______

6. These immunizations are required by North Carolina state law (*General Statute 130-87*) and must be completed in full and signed by physician before the student can be accepted.

Vaccine	Date	Date	Date	Date	Date
DTaP* (5 doses)					
TdaP (1 dose)		One booster for students 12 yrs of age after 8-1-08, if five years or more have passed since the last dose of tetanus/diphtheria toxoid			
Polio (4 doses)					**
Hepatitis B (3 doses)					
MMR (2 doses)					

**If third dose of Polio vaccine administered on or after 4th birthday, the fourth does is not required.

Physician's Signature or Clinic Stamp ____________________ Date ____________________