WAUKEE COMMUNITY SCHOOL DISTRICT

MEDICAL REPORT

Student Name_____ Gender M F Birthdate _____
Parents/Guardian Name_____
Address_____ City_____ State_____
School of Attendance_____

SIGNIFICANT HEALTH HISTORY

Yes	No		Yes	No	
		Asthma			**Hospitalizations** (List Below)
		Seizure Disorder			**Surgeries** (List Below)
		Diabetes			**Allergies**
		Heart Disorder			
		Pleurisy/Pneumonia			
		Rheumatic Fever			
		Scarlet Fever			**Medications**
		Eczema			
		Meningitis			
		Chicken Pox			
		Other (List Below)			

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PHYSICAL EXAMINATION / PHYSICIAN REPORT X = Normal or Negative

			Results
	Appearance	Height	
	Posture	Weight	
	Nutrition	Blood Pressure	
	Development	Hemoglobin	
	Neurological	Urinalysis	
	Speech Defect	Blood Lead Level **(Required)**	Date Completed_____
	Hair and Scalp	Hearing Screening	Referral Yes____ No____
	Nose	Vision Screening **(Required)**	**R** 20 / **L** 20 / **Both** 20/ Referral Yes_____ No _____
	Ears		
	Throat	Chronic Disease	
	Thyroid	Physical Education	Full _____ Limited _____ None _____
	Lymph Nodes	Anatomical Restrictions	
	Heart	**Physician's Comments and Recommendations**	
	Lungs		
	Extremities		
	Abdomen		
	Skin		
	Hernia		
	Back		

Physicians Signature_____ Date of Exam_____