BLUE SPRINGS SCHOOL DISTRICT
OFFICE OF HEALTH SERVICES

Private Physician's Medical Examination Report

(Confidential Report – This report to be returned directly to the school nurse)

Student's Name _____ DOB _____ Age on Exam _____

IMMUNIZATION RECORD – MUST HAVE COMPLETE MONTH, DATE, AND YEAR							
DTaP/DT	**Td**	**POLIO**	**HEP B**	**HIB**	**MMR**	**VARICELLA**	**HEP A**
OTHER							

Date of Exam _____ **ALL INFORMATION MUST BE WITHIN PAST 12 MONTHS**

Height _____ Weight _____ %tile _____ Bp _____ Temp _____

Vision: Rt _____ Lt _____ Both _____ Hearing: Rt _____ Lt _____

Review of systems	Normal	Abnormal – comments / recommended follow-up
Eyes		
Ears, Nose & Throat		
Teeth/Gums		
Skin		
Cardiovascular		
Respiratory		
Muscular Skeleton		
Genitalia		
Mental		

Laboratory tests (required): Hgb/Hct _____ UA _____ Blood lead _____ Sickle cell _____
Comments/Recommended Follow-up _____

Please check the appropriate box as it pertains to this child

☐ I have examined the above mentioned child and found the child to be in good general health and capable of full participation in either an Early Childhood, Elementary, Middle, or Secondary Education program.

☐ I have examined the above mentioned child and found that due to a physical condition, the child is capable of participation in either an Early Childhood, Elementary, Middle, or Secondary Education program with the following limitations (please add additional pages as needed) _____

_____

_____

Physician name _____ Address _____
PLEASE PRINT

Physician signature _____ Phone _____