

CERTIFICATE OF SCHOOL HEALTH EXAMINATION
THIS SIDE TO BE COMPLETED BY PHYSICIAN

Student's Name _____
Age _____ Height _____ Weight _____
Urine: Albumin _____ Sugar _____ Other _____ Blood Pressure _____

SYSTEMS EXAMINATION	EXAMINED	COMMENTS ABOUT FINDINGS
General Appearance, Nutrition		
Posture, scoliosis		
Skin		
Vision: With Glasses R20/ ___ L20/ ___ Without Glasses R20/ ___ L20/ ___		
Eyes: External Fundi		
Nose		
Teeth		
Throat		
Ears: External & Canal Tympanic Membrane		
Neck		
Heart		
Lungs		
Abdomen		
Bones, Joints, Muscles		
Neurological: Gait		
Balance		
Fine Motor		
Other		
Hematocrit (optional, if needed)		

BEHAVIOR DURING EXAMINATION		
Cooperative		
Emotional Tone		
Activity Level		

Summary of abnormal or disabling conditions which may require activities to be limited: _____

Any developmental delays noted: _____

Further diagnostic or treatment service recommended by the undersigned: _____

Recommended follow up by health or social services other than undersigned: _____

Prescription medicines taken regularly to be administered at school: _____

Signed _____
Examining Physician

____/____/____
Date of Examination

Address _____

____-____-____
Phone Number

____/____/____
Date Form Completed