2023-2024 Medical Examination

DISCOVERY CHARTER SCHOOL

Student Name: _____

Date of Birth: _____/_____/_____

Grade: _____

Parent(s) or Guardian(s): _____

Home Phone: _____ Cell Phone: _____

Street Address: _____ City, ST, ZIP: _____

Doctor's Name: _____ Phone: _____

Doctor's Address: _____ City, ST, ZIP: _____

Health information to be completed by physician:

Allergies:	
On Medication:	
Vision Difficulties:	
Hearing Difficulties:	
Physical Restrictions:	

Current height: _____ Current weight: _____

Is the child currently under medical treatment? _____Yes _____No

If yes, state reason: _____

Based on today's physical exam, the review of body systems is within normal limits with the exception of: _____

_____

Speech or Language Development concerns: _____

Does the student have a diagnosis of ADD/ ADHD: _____

Please list any behavioral or mental health issues: _____

Does the child have Asthma? _____Yes* _____No *If yes, also complete Asthma Action Plan Form.

If yes, please indicate triggers: _____

Does the child have a SEVERE ALLERGY requiring epinephrine to be available at school? _____Yes* _____No

*If yes complete AAP Allergy Action Plan. Please indicate severe allergy: _____

Is the child up to date on their immunizations for school entry? _____Yes _____No* *if no, please indicate reason_____

PLEASE ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORDS TO THIS FORM.

Physician/ Health Care Provider signature: _____ Date: ____/____/____