

2018-2019 Medical Examination



DISCOVERY
CHARTER SCHOOL

Student Name: _____

Date of Birth: ____/____/____

Grade: ____

Parent(s) or Guardian(s):

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?: _____

Significant past medical history/ surgeries: _____

Does the child have ASTHMA? ____Yes ____No (If yes, please fill out Asthma Action Plan)

If yes, please indicate triggers: _____

Does the child have a SEVERE FOOD ALLERGY? ____Yes ____No (If yes, please complete FARE Action Plan)

If yes, please indicate allergy _____

Is the child up to date on their immunizations for school entry? ____Yes ____No (If no, please explain):

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

Physician Signature: _____ Date: ____/____/____