DATE _____

LCA MEDICAL EXAMINATION BY A PHYSICIAN

FOR ELEMENTARY SCHOOL PUPIL

A physician must fill in this form.

Name of student: _____ Age: _____ Grade: _____

Street or POB: _____

City, State and Zip: _____

List all significant illnesses, accidents, operations, congenital defects, family history or other: _____

_____

List any significant factors in the home situation: _____

_____

Please check boxes below if any positive findings upon medical examination or any handicapping disabilities are discovered. Describe each checked item on line to right. If no check appears, condition will be assumed normal.

☐ SKIN _____ ☐ LUNGS _____

☐ EYES _____ ☐ ABDOMEN _____

☐ EARS _____ ☐ HERNIA _____

☐ NOSE & THROAT _____ ☐ EXTREMETIES _____

☐ MOUTH _____ ☐ GENITO-URINARY _____

☐ GLANDS _____ ☐ NUTRITION _____

☐ HEART _____ ☐ TEETH _____

Vision (if done): R _____ L _____ Hearing (if done): R _____ L _____

Hemoglobin _____ Height _____ Weight: _____

Specify medical recommendations to school for academic and activity program, if necessary: _____

_____

_____

_____ _____

Signature of Examining Physician Date

_____ _____

Printed Name Phone Number