DES MOINES CATHOLIC SCHOOLS

STUDENT MEDICAL REPORT

Last Name	First Name	School	Grade
Birthdate	Birthplace	Sex	Phone
Parent's Name or Guardian		Address	Zip Code

ILLNESS / DISEASE		Dates of Immunization					
Epilepsy	Whooping Cough						
Chickenpox	Measles (red)	Diptheria					
Diabetes	Mumps	Pertussis					
TB	Rubella	Tetanus					
Rheumatic Fever		Hib					
Other Illnesses / Surgery-		Polio					
		MMR					
Allergies-		Hep.B					
		Varicella					

√ = normal or negative **PHYSICAL EXAMINATION**

Appearance	Ear	Hernia
Posture	Nose	Back
Nutrition	Throat	Extremities
Development	Lymph nodes	Blood Pressure
Vision- R __/20 L __/20	Heart	Hemoglobin
Neurological	Thyroid	Urine Analysis
Skin	Lungs	Height
Hair & Scalp	Abdomen	Weight
Eyes	Genitals	Other *(Lead)

Chronic Disease	Medications

Remedial Defect

Physical Education Program: Full Limited None

Reason for Limitation

Physician's Comments & Recommendations'

Important Medical Information

Date of Examination. * Physician

*Address
*Phone