Medical Examination Record

School/Escuela _____

** Esta forma se debe de regresar durante la registración o durante la primer semana de clases.**

Esta parte debe ser completada por Padre/Guardián:

Nombre del Estudiante: _____

Padre/Guardián: _____

Dirección: _____ Teléfono: _____

Fecha de Nacimiento: _____ Sexo: Masculino _____ Femenino _____

¿Ha un oculista examinado los ojos de su hijo? Si _____ No _____

¿Por qué fue examinado y cual fue el resultado? _____

Fecha del ultimo examen dental: _____

**Recordatorio: se recomienda un examen de la vista y dental antes de entrar a la escuela. **

Completed by Physician, Nurse Practitioner or Physician's Assistant:

Note to Clinician: This examination must have been completed within the one year period preceding the date of enrollment. The cost of the medical evaluation is the responsibility of the parent, legal guardian or legal custodian of the student.

Medical Conditions, Serious Illnesses or Past Hospitalizations of significance to school personnel (include allergies):
_____
_____
_____

Any physical limitations that indicate the student should restrict or not participate in outdoor play or physical education (Be specific): _____
_____

Is there evidence of or treatment for an emotional or behavioral problem? Yes _____ No _____

List medications the student takes at home or will be taking at school:
_____
_____
_____

Please indicate any school nursing intervention or consultation that is needed:
_____

Date of examination: _____ **Date of Report Completion:**_____

Clinician Signature: _____

Clinician Name and Address (Print): _____

_____ **Phone:** _____