MEDICAL EXAM

MOUNT VERNON WASHINGTON ELEMENTARY SCHOOL

FOR PRESCHOOL AND KINDERGARTEN STUDENTS

TO BE COMPLETED BY PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE PRACTITIONER
(✓ = normal; describe impairments)

STUDENT'S NAME _____

HEIGHT_____ WEIGHT _____ HEAD CIRCUMFERENCE (cm) _____

URINALYSIS_____ HEMOGLOBIN/HEMATOCRIT_____

FOR KINDERGARTEN STUDENT ONLY

LEAD LEVEL _____

VISUAL ACUITY (E chart) LEFT_____ RIGHT _____ STRABISMUS? _____
(Parents must complete all other vision forms)

SKIN_____

HEARING ACUITY (whispered voice)_____

EYES_____ ENT _____

HEART _____ LUNGS_____

ABDOMEN_____ GENITALIA_____

EXTREMITIES _____ REFLEXES_____

COORDINATION: Gross Good _____ Poor _____

Balance Good _____ Poor _____

Fine Good _____ Poor _____

HYPERACTIVE DURING EXAM? Yes___ No___ Comments _____

COOPERATED WELL DURING EXAM Yes___ No___ Comments _____

TAKES DIRECTIONS WELL Yes___ No___ Comments_____

KNOWS FULL NAME, AGE, AND SEX Yes___ No___ Comments_____

COUNTS TO TEN Yes___ No___ Comments_____

COPIES A SQUARE Yes___ No___ Comments _____

DID YOU RECOMMEND A REFERRAL? (ENT, Eye, Orthopedic, Urol., etc.) Yes_____ No _____

IF YES, WHAT KIND? _____

DO YOU FEEL HE/SHE NEEDS A FURTHER EVALUATION? (psychological, educational, speech)

Yes_____ No _____ Comments _____

_____

OTHER RECOMMENDATIONS _____

SIGNATURE _____ DATE _____

(Physician, Physician's Assistant, Nurse Practitioner)

PRINTED NAME OF HEALTH CARE PROVIDER_____

3.28.17