MOC-FV Community School District
School Medical Report

Name_____D.O.B._____M/F_____Grade:_____

Parent or Guardian_____Phone_____

School_____

Allergies_____ Physician_____

PHYSICAL EXAMINATION

√ = normal or negative

Appearance	Ears	Hernia
Posture	Nose	Back
Nutrition	Throat	Extremities
Development	Lymph nodes	Blood Pressure
Neurological	Thyroid	Urine Analysis
Speech	Heart	Hemoglobin
Skin	Lungs	Height
Hair/Scalp	Abdomen	Weight
Eyes/Vision	Genitalia	Other

******PLEASE ATTACH A LIST OF CURRENT IMMUNIZATIONS******

Date of Vision Screening_____**Results: R**_____**/**_____**;L**_____**/**_____

Date of Lead Level Screen_____Result:_____

Date of Dental Screen_____

Medications_____

Chronic Disease_____

Mental Health_____

Surgeries/Hospitalizations_____

Physician's Comments and Recommendations_____

_____

Physician's Signature_____Date of Exam_____