## **SCHOOL MEDICAL REPORT- Algona Community Schools**

Parents/Guardians Phone	Name		Birthdate	Sex	
PHYSICAL EXAMINATION  WNL = negative or normal Height					
PHYSICAL EXAMINATION  WNL = negative or normal Height Weight BMI Blood Pressure Appearance Posture Thyroid Skin Heart Hair/scalp Lungs Eyes Abdomen Ears Hernia Nose Genitalia Throat Back/scoliosis Tonsils/adenoids Extremities  Current Assessments  Nutrition Blood count Development Vaccine History - Up-to-date Needs Neurological Please attach an updated Certificate of Immunization Family dynamics Other  History/General Health Asthma Scarlet fever Seizure Disorder Mononucleosis Heart Disorder Pneumonia Bleeding Disorder Pneumonia Bleeding Disorder Frequent ear infections Mental health Issues Tuberculosis Rheumatic fever Bone/musculoskeletal conditions  Allergies - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list VISION EXAMINATION  Visual Acuity - Without correction - Distance- R With glasses or contacts  Diagnosis Comments/Recommendations					
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Eyes	Hair/scalp		_ Lungs	Lungs	
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Nose	Ears		Hernia	Hernia	
Throat Tonsils/adenoids	Nose		Genitalia	Genitalia	
Current Assessments  Nutrition	Throat		_ Back/scoliosis	Back/scoliosis	
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Bleeding Disorder	Heart Disorder		Pneumonia		
Mental health issues Tuberculosis	Bleeding Disorder		Frequent ear infe	Frequent ear infections	
Rheumatic feverBone/musculoskeletal conditions					
Allergies - please list Lead testing dates - Please note if any results were elevated. Current medications and dosages - please list  Physician Comments/Recommendations Date of Exam Signature of Physician  VISION EXAMINATION  Visual Acuity - Without correction - Distance- R With glasses or contacts Diagnosis Comments/Recommendations					
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