

**SCHOOL MEDICAL REPORT- Algona Community Schools**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_  
Parents/Guardians \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**PHYSICAL EXAMINATION**

WNL = negative or normal  
Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Appearance \_\_\_\_\_ Lymph Nodes \_\_\_\_\_  
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**  
Speech \_\_\_\_\_ Family dynamics \_\_\_\_\_  
Urinalysis \_\_\_\_\_ Other \_\_\_\_\_

**History/General Health**

Asthma \_\_\_\_\_ Scarlet fever \_\_\_\_\_  
Seizure Disorder \_\_\_\_\_ Mononucleosis \_\_\_\_\_  
Diabetes \_\_\_\_\_ Hepatitis \_\_\_\_\_  
Heart 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 \_\_\_\_\_

Physician Comments/Recommendations \_\_\_\_\_  
Date of Exam \_\_\_\_\_ Signature of Physician \_\_\_\_\_

**VISION EXAMINATION**

Visual Acuity - Without correction - Distance- R \_\_\_\_\_ L \_\_\_\_\_ Near- R \_\_\_\_\_ L \_\_\_\_\_  
With glasses or contacts \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Comments/Recommendations \_\_\_\_\_  
Date of Exam \_\_\_\_\_ Signature of Eye Care Professional \_\_\_\_\_