

MIDDLEBURY COMMUNITY SCHOOLS

**Health Services**

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Month/day/year  
Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

**This form must be back by the first day of school.**

**DOCTOR'S EXAMINATION**

Eyes \_\_\_\_\_ Ears \_\_\_\_\_  
Visual Acuity L \_\_\_\_\_ R \_\_\_\_\_ Hearing (gross) \_\_\_\_\_  
Wears Glasses \_\_\_\_\_  
Referred to eye specialist \_\_\_\_\_

Weight \_\_\_\_\_ Urinalysis \_\_\_\_\_  
Height \_\_\_\_\_ Hemoglobin \_\_\_\_\_  
Blood Pressure \_\_\_\_\_ or Hematocrit \_\_\_\_\_  
Nose \_\_\_\_\_ Abdomen \_\_\_\_\_  
Throat \_\_\_\_\_ Hernia \_\_\_\_\_  
Lungs \_\_\_\_\_ Genitalia \_\_\_\_\_  
Skin \_\_\_\_\_ Orthopedic \_\_\_\_\_  
Lymph Glands \_\_\_\_\_ Allergies \_\_\_\_\_

(If student has insect sting allergies, please indicate appropriate treatment.) \_\_\_\_\_  
\_\_\_\_\_

**Had Chicken Pox?** \_\_\_\_\_ **date** **MD initial** \_\_\_\_\_

Physically fit to participate in physical education program? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Competitive sports? Yes \_\_\_\_\_ No \_\_\_\_\_

Restriction? \_\_\_\_\_ Please explain \_\_\_\_\_  
 \_\_\_\_\_

Date of Examination \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_  
 Physician's Signature

**IMMUNIZATIONS: (To be filled out by: parent, using student's personal health records, or Doctor's office, may send a copy of their records or list the month, day and year for each)**

	# 1	# 2	# 3	# 4	# 5	# 6
	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr	mo/day/yr
DPT						
Td						
IPV, OPV which one						
Hep.B						
H.I.B.						
*Chicken Pox						
M.M.R.						
Measles						
Rubella						
Mumps						