USHINDI SECONDARY SCHOOL

Medical Examination Form

STUDENT INFORMATION

Name: _____ Date of Exam:_____
Address:_____ Date of Birth:_____
_____ Class:_____

Sex: ☐ Male ☐ Female

Name of father:_____ Phone No:_____
Name of Mother:_____ Phone No:_____
Name of Family Physician (if any): _____
Facility Name: _____
Phone No:_____ E-mail: _____
Insurance (Medical) Company:_____
Insurance No:_____
DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS: (Include a Medical History Summary and Chronic Health Problems list, if available)

CURRENT MEDICATIONS:

Medication name	Dose	Frequency	Diagnosis	Physician specialty	Date of Medication Prescribed

Does the person take medication independently? Yes ☐ No ☐

Allergies/Sensitivities:_____
Contraindicated Medication:_____

IMMUNIZATIONS:

Tetanus/Diphtheria (every 10 years):_____/_____/_____
Hepatitis B #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____
Covid19 #1_____/_____/_____ #2_____/_____/_____
Others (Specify)_____
_____
_____

HOSPITALIZATION/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

GENERAL PHYSICAL EXAMINATION

Blood Pressure:_____/_____ Pulse:_____ Respirations:_____
Temp:_____ Height:_____ Weight:_____

EVALUATION OF SYSTEMS

System Name	**Normal Findings**	**Comments/Description**
Eyes	Yes/No	
Ears	Yes/No	
Nose	Yes/No	
Mouth/Throat	Yes/No	
Head/Face/Neck	Yes/No	
Breasts	Yes/No	
Lungs	Yes/No	
Cardiovascular	Yes/No	
Extremities	Yes/No	
Abdomen	Yes/No	
Gastrointestinal	Yes/No	
Musculoskeletal	Yes/No	
Integumentary	Yes/No	
Renal/Urinary	Yes/No	
Reproductive	Yes/No	
Lymphatic	Yes/No	
Endocrine	Yes/No	
Nervous System	Yes/No	
VISION SCREENING	Yes/No	Is further evaluation recommended by specialist? Yes ☐ No ☐
HEARING SCREENING	Yes/No	Is further evaluation recommended by specialist? Yes ☐ No ☐

Physician Information

Name of Physician (Please Print):_____

Physician's Signature:_____ Date:_____

Physician's Address: _____

Phone Number:_____ E-mail Address:_____