Scholars' Preparatory School Medical Form

Petersfield Road Tel: 242-6772831

Name_____ ☐ Male ☐ Female D.O.B _____

Current Health Issues

Y N

☐ ☐ Allergies: Please List: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (Please Attach)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure Disorder: _____

☐ ☐ Other (Please Specify)

_____

Current Medications (if relevant to the student's health and safety) _____

Physical Examination Date of Examination _____

Hgt:_____ Wgt: _____ BMI _____ BP _____
(Check = Normal ? If abnormal, please describe)_

☐ General_____ ☐ Lungs_____ ☐ Extremities _____

☐ Skin_____ ☐ Heart _____ ☐ Neurologic _____

☐ HEENT_____ ☐ Abdomen _____ ☐ Other _____

☐ Dental/Oral_____ ☐ Genitalia _____

Screening:

	Pass	Fail		Pass	Fail		Pass	Fail
Vision: Right Eye	☐	☐	Hearing: Right Ear	☐	☐	Personal Screening	☐	☐
Vision: Left Eye	☐	☐	Left Ear	☐	☐	(Scoliosis/Kyphosis/Lordosis)		
Stereopsis	☐	☐						

Laboratory Results: ☐ Lead_____ Date_____ ☐
Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk
(Exposure to TB; born, lived, travel to TB endemic countries; medical risk factors:TB Test Type: ☐ TST ☐ IGRA
Date:_____ Result: ☐ Positive ☐ Negative ☐ Indeterminate/Borderline
Referred for Evaluation to: _____ Date: _____

☐ Y ☐ N This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions: _____

☐ Y ☐ N Immunizations are complete: Please attach a copy of Immunization Record

OFFICIAL USE ONLY

_____ Date: _____
Signature of Medical Examiner

_____ Tel: _____
Address

MEDICAL STAMP