

# Early Education Medical Report

**One form per student**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Class Entering: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Diseases</b> <small>(Dates of Immunization – Month/Year)</small>	
Tdap	Meningococcal
Polio	HepA
MMR	
Hib	
HepB	
Varicella	
Pneumo	

<b>Illnesses</b>	
Allergy	Measles (Red)
Chickenpox	Mumps
Diabetes	Rheumatic Fever
Epilepsy	Tuberculosis
Rubella (3 Day Measles)	Whooping Cough
Other Illnesses And Surgery	

**Physical Examination** Check Mark = Normal or Negative Blood Type: \_\_\_\_\_

appearance	ears	extremities	chronic disease
posture	nose	blood pressure	medications
nutrition	throat	urine analysis	remedial defects
speech defect	lymph nodes	hemoglobin	physical education program (circle one) full    limited    none reason for limitation: _____ _____ _____
skin	thyroid	height	
hair/scalp	heart	weight	
eyes/vision	lungs	neurological	
hernia	abdomen	development	
back	genitalia	other	

**Physician's Comments or Recommendations:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Important Medical Information:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Physician: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Return to:  
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