School District of Holmen

502 North Main Street, P.O. Box 580
Holmen, Wisconsin 54636
(608) 526-6610
www.holmen.k12.wi.us

MEDICAL EXAMINATION

STUDENT'S NAME: ____ **GRADE:** __________

PARENT(S)/GUARDIAN(S): ____

ADDRESS/CITY/STATE/ZIP: ____

PHONE NUMBER: __________________________ **DATE OF BIRTH** __________________________

SCHOOL YEAR: ____________________ **SCHOOL ATTENDING:** ____________________________

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**Are there concerns with any of the following areas? If yes, describe with recommendations for school personnel.

AREAS	YES	NO	RECOMMENDATIONS
Growth/Development/Nutrition			
Spine/Posture			
Eyes			VISION:
Ears			HEARING:
Nose			
Throat			
Heart			
Lungs			
Abdomen			
Scalp/Skin/Scars			
Extremities			
Allergies			
Asthma			
Headaches			
Seizures			
Diabetes			
Operations/Serious Injuries			
Speech			
Other			
Height:			
Weight:			

αIs this student subject to limited conditions in classroom/physical education? ρ YES ρ NO

If yes, please explain: ____

αIs this student on a special diet? ρ YES ρ NO

If yes, please explain: ____

(OVER)
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αIs this student on medication during school hours? ρ YES ρ NO

If yes, list medication, dose, time or frequency: ____________________

****NOTE:*** A "Medication Form" MUST be completed with parent AND physician's signature for administration of medication at school. These forms are available from the physician or the school.

Tuberculin test (optional) DATE: ____________________ ρ Positive ρ Negative

Chest X-ray if positive Tuberculin DATE: ____________________ Follow-up: ρ YES ρ NO

Results of any additional tests deemed necessary by physician: ____________________

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COMMENTS/RECOMMENDATIONS: ____________________

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7____________________ ____________________

Signature of Examining Physician Date

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STUDENT IMMUNIZATION RECORD

Wisconsin State Law requires all public and private school students to present written evidence of immunization against certain diseases. The current age/grade specific requirements are available from schools and local public health agencies. These requirements can be waived only if a properly signed health, religious or personal conviction waiver is filed with the school.

IMMUNIZATION HISTORY

List the **MONTH, DAY and YEAR** your child received each of the following immunizations. **DO NOT USE** a (4) or (7). If you do not have an immunization record for this student at home, contact your doctor or public health agency to obtain the dates.

TYPE OF VACCINE	FIRST DOSE month/day/year	SECOND DOSE month/day/year	THIRD DOSE month/day/year	FOURTH DOSE month/day/year	FIFTH DOSE month/day/year
DTP/DT/DTaP/TD					
POLIO					
MMR					
MMR					
HIB					
HEPATITIS B					
VARICELLA (Chicken Pox)					

WAIVERS

ρ **For health reasons,** this student should not receive the following immunization(s): ____________________

____

Physician's Signature: ____________________

π **For religious reasons,** this student should not be immunized. (List immunizations received.)

π **For personal conviction reasons,** this student should not be immunized. (List immunizations received.)

This form is complete and accurate to the best of my knowledge.

7____________________ ____________________

Signature of Parent/Guardian/Legal Custodian or Adult Student Date
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