Carl T. Mitnick School
905 Seashore Road
Cape May, New Jersey 08204
(609) 884-9470 - *MAIN OFFICE*

Report of Student Medical Examination

Grades Preschool through Grade 6

This form is to be completed by the student's "medical home" (family physician or advanced practice nurse.)

Student Name: _____ Grade: _____ Age: _____ Sex: _____ Date of Birth: _____

Examination Date: _____ Physician's Name: _____ Physician's Phone: _____

Medical History (include allergies, past serious illnesses, injuries and operations, medications, diabetes, familial disorders and current health problems):

_____

_____

_____

Current Status:

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____ bpm

Vision:	NEAR R 20/_____ L 20/_____	FAR R 20/_____ L 20/_____	Corrected: Contacts: Glasses:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Hearing:	R _____	☐ Pass ☐ Fail	L _____	☐ Pass ☐ Fail

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose			
Throat			
Teeth-Mouth			
Heart: *Murmurs/Rhythms*			
Lungs *Auscultation/Percussion*			
Chest Contour			
Skin			
Abdomen Assessment *(including liver, spleen)*			
Tanner Stage *Testes/Onset of Menses*			

	Normal	Abnormal Findings	Comments
Hernia			
Neck/Back/Spine *(Range of Motion)*			
Scoliosis			
Upper Extremities			
Lower Extremities			

Neurological: Balance and Coordination

▪ Romberg			
▪ Heel Walk			
▪ Tandem Walk			
▪ Nose Touch			
▪ Toe Walk			

Most Recent Immunizations/Dates

DTaP		**MMR**		**Varicella**	
IPV/OPV		**Hib**		**Hepatitis B**	
Influenza		**PCV7**		**Meningococcal**	

Medications Currently in Use

Additional Observations

Are there any modifications required for full participation in school? ☐ YES ☐ NO If yes, please explain below:

_____

_____

Family Physician/Provider ☐ YES ☐ NO School Physician ☐ YES ☐ NO

____ MD ____ DO ____ NP ____ PA

Examining Physician's/Provider's Signature: _____

Date: _____