

REDEEMER LUTHERAN SCHOOL
205 S. Hudson Street, Green Bay, Wisconsin 54303

MEDICAL EVALUATION RECORD

It is required that all children have physical examination prior to initial school entrance.

I. TO BE COMPLETED BY PARENT BEFORE EXAMINATION BY PHYSICIAN.

Child's Name _____ Birth date _____ Sex _____

Parent or Guardian's Name _____

Address _____
City State Zip Code

II. TO BE COMPLETED BY PHYSICIAN.

A. Immunizations (Complete the Student Immunization Record. Include dates of all shots. This information may be obtained wherever you had the immunizations done.)

B. Diagnostic Procedures

Tuberculin Test: Date _____ Result _____

C. Is child subject to conditions which may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, other? Yes () No ()

Please list allergies, if any:

D. Does child have any other medical problem with which the school should be concerned? Yes () No ()

E. Any hearing or visual defect for which preferential seating or other action is needed? Yes () No ()
Has this child ever had a vision or hearing exam? Yes () No ()

F. Any ocular defect which indicates need for referral to eye doctor? Yes () No ()

G. Is there any defect such as heart condition which limits student's participation in:
Classroom activities Yes () No () ; Physical Education Yes () No ()

H. Physician's recommendation to school concerning C through G:

I. I would like the nurse (), teacher () to contact me regarding this child.

J. Date of examination _____ Signature _____

It is optional that all children have a dental examination prior to initial school entrance.

Name _____ **Date** _____

To be completed by Dentist:

Condition of the gingiva (gums) and supporting tissues: Satisfactory _____ **Infection present** _____

Relationship of anterior teeth when biting on posterior teeth: Closed _____ **Open** _____

Evidence of detriment habits to the oral cavity: Thumbsucking Yes _____ **No** _____

Tongue Thrusting Yes _____ **No** _____

Evidence of decay of the teeth: Yes _____ **No** _____

Additional appointment is necessary Yes _____ **No** _____

Dentist's recommendation to school regarding the above report:

Date _____ **Examining Dentist** _____