Fall Creek Elementary

MEDICAL EXAMINATION

Student Name: ____ Date of Birth: __________________

Health Care Provider to complete.

Height:_______ Weight:______ Blood Pressure:_______ Pulse:________ Gross: __________________
Dental:(teeth/gums)______________

Vision Screen: Right Eye:_____ Left Eye:_______ Hearing Screening: Right Ear _____Left Ear:______

Immunizations Given: ____

Prescribed Medications: ____

Significant physical/mental health findings: ____

Recommendations for school staff or school nurse follow up: ___________________________________

____

Health Care Provider Signature:_________________________ Name:(Print) __________________

Phone:_________________________________ Date:_____________

DENTAL EXAMINATION

To the Parents:

Our School has a health program that is designed to improve, protect, and promote the health of each student. As a part of this health program we urge you to take your child to the dentist of your choice at least once per year for a dental examination and for whatever treatment may be necessary.

To the Dentist:

Check the following statements before signing this card:

( ) No dental work necessary.

( ) All immediate dental work has been completed.

( ) Necessary dental work in progress.

Dentist Signature ____ Date______________________

When the examinations are complete, please return this form to school.