

Medical Exam Form

TO BE COMPLETED BY THE DOCTOR

Revised 10/07

FAITH ACADEMY MINDANAO

PASSPORT NAME: _____ PREFERRED NAME: _____
SEX: M F BIRTH DATE: (MM/DD/YY) _____ GRADE (in which enrolling) _____

MEDICAL EXAMINATION

General Appearance _____	Ears _____	Pulse _____
General Nutrition _____	Nose & throat _____	Abdomen _____
Posture (Scoliosis) Yes _____ No _____	Mouth _____	Bones & Muscle _____
Height _____	Teeth & gums _____	Nervous System _____
Weight _____	Glands _____	Emotional Problems _____
Skin _____	Breasts _____	Vision _____
Scalp _____	Lungs _____	Other _____
Eyes & lids _____	Heart murmurs _____	
_____	Blood pressure _____	

ALLERGIES & REACTION: _____

CHRONIC MEDICAL CONDITIONS: (eg. Diabetes, asthma): _____

ANY LABORATORY TESTS DONE AND RESULTS: _____

RECOMMENDATIONS:

- | | | |
|---|-----------|----------|
| 1. Is special seating recommended? | Yes _____ | No _____ |
| 2. Does pupil have any uncorrectable defects? | Yes _____ | No _____ |
| 3. Does he require any regular medication? | Yes _____ | No _____ |
| 4. Does pupil require continuing medical treatment? | Yes _____ | No _____ |
| 5. Is there evidence of emotional upset? | Yes _____ | No _____ |
| 6. Is there need for dietary corrections? | Yes _____ | No _____ |
| 7. Does pupil require vision correction? | Yes _____ | No _____ |

1 - 7 - if yes, explain:

Is pupil capable of carrying a full academic work load? Yes _____ No _____

PHYSICAL ACTIVITY & SPORTS RECOMMENDATIONS:

Is pupil capable of unlimited physical activity? Yes _____ No _____

****If NO, please give specific guidelines or restriction: _____

PHYSICIAN'S NAME _____
Please print or type name *Name of Hospital or Clinic*

PHYSICIAN'S SIGNATURE _____ Phone #: _____

DATE OF EXAM: _____