

**ELMONT UNION FREE SCHOOL DISTRICT
SCHOOL HEALTH SERVICE
ELMONT, NEW YORK 11003**

NEW ENTRANT'S MEDICAL REPORT

Pupil's Name: _____ Telephone: _____ Date of Birth: _____

Address: _____ School: _____

Test Required - Required for Elmont School District

TUBERCULIN TEST: WITHIN ONE (1) YEAR PRIOR TO ENTRANCE OF SCHOOL
(Only one of the following tuberculin tests is required)

1. MANTOUX TEST: Date: _____ Results: Negative () _____ mm
Positive () _____ mm
2. CHEST X-RAY: Date: _____ Results: Negative () Positive ()

Hemoglobin: Date: _____ Results _____
Urinalysis: Date: _____ Sugar _____ Albumin _____ Microscopic _____

SIGNIFICANT FAMILY HISTORY (Family Member Other Than Student - Please Circle)

Allergies Chorea Diabetes Meningitis Recurrent Otitis Asthma
Rheumatic Fever Seizures Tuberculosis or other serious illness/injuries or operations:

DISEASE CHILD HAS HAD: (Please give date)

Chicken Pox _____ Measles _____ Scarlet Fever _____
Diphtheria _____ Mumps _____ Whooping Cough _____
German Measles _____ Poliomyelitis _____ Other _____
Fifth Disease _____ Hepatitis _____ Other _____

PHYSICAL EXAMINATION: Blood Pressure _____ Pulse _____ Weight _____ Height _____

BMI _____ = Weight _____ (lbs) ÷ Height _____ (in) ÷ Height _____ (in) x 703

Weight Status Category (check one): () less than 5th () 5th to 49th () 50th to 84th () 85th to 94th () 95th to 98th () 99th and higher

Fill in where appropriate and when **ABNORMAL** and describe below:

EENT _____ Heart _____ Orthopedic _____ () Immunization record attached
Abdomen _____ Lungs _____ Diabetes _____ () No immunizations given today
Genitourinary _____ Asthma _____ Neurology _____
Hernia _____ Speech _____ Skin _____ Other: _____

Tanner: (please circle) I. II. III. IV. V.

Amblyopia Screening: () negative () positive: _____
Scoliosis: () negative () positive: _____
Sickle Cell: () negative () positive: _____
Lead Screening: () negative () positive: _____

	<i>Referral</i>		
Vision: without glasses/contact lens	R	L	
Vision: with glasses/contact lens	R	L	
Vision: Near point	R	L	
Hearing: () Pass 20db both ears or:	R	L	

Does the child wear a hearing aid? No () Yes () Right or Left Ear Braces: () No () Yes

Does the child have any allergies? No () Yes () Specify _____

Is the allergy **LIFE THREATENING** No () Yes () Seasonal No () Yes ()

Treatment Advised _____

Does the child take any medication on a regular basis? No () Yes () _____

Accommodations, which might assist school personnel _____

Can this child participate in full physical activities? Yes () No () Specify _____

Examiner's Signature _____ **M.D.** **Date of Exam** _____
Address _____ **Telephone** _____

****PHYSICIAN'S SIGNATURE AND OFFICE STAMP MUST BE PRESENT****