

**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: _____

1. Test Required - Required for Elmont School District

**TUBERCULIN TEST: WITHIN ONE (1) YEAR PRIOR TO ENTRANCE OF THIS SCHOOL DISTRICT
(Chest X-Ray required if Mantoux Test is Positive)**

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 _____

2. 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:

3. DISEASE CHILD HAS HAD: (Please give date)

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

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

BMI= _____

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

Weight Status Category: (check one)

<input type="checkbox"/> less than 5th	<input type="checkbox"/> 5th - 49th	<input type="checkbox"/> 50th - 84th
<input type="checkbox"/> 85th - 94th	<input type="checkbox"/> 95th - 98th	<input type="checkbox"/> 99th and higher

Immunization record attached
 No immunizations given today

Record findings where appropriate and when **ABNORMAL** and describe below:

EENT _____ Skin _____ Lungs _____ Heart _____ Other: _____
Abdomen _____ Orthopedic _____ Asthma _____ Hyperlipidemia _____
Genitourinary _____ Neurology _____ Diabetes Type 1 _____ Hypertension _____
Hernia _____ Seizures _____ Type 2 _____ Cholesterol: normal high _____

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>	
	R	L
Vision: without glasses/contact lens		
Vision: with glasses/contact lens		
Vision: Near point		
Hearing: <input type="checkbox"/> Pass 20db both ears or:	R	L

Allergies: No Yes Seasonal Insect: _____ Food: _____ Other: _____
 LIFE THREATENING Treatment Advised: _____

Does the child wear a hearing aid? No Yes: Right or Left Ear Braces: No Yes Appliances: No Yes _____
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: _____
Address: _____
Telephone: _____
Date of Exam: _____

****PHYSICIAN SIGNATURE & OFFICE STAMP
MUST BE PRESENT****