DISCOVERY SCHOOL
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Mansfield, Ohio 44903
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SCHOOL ENTRANCE MEDICAL RECORD

(TO BE COMPLETED BY PHYSICIAN)

(Form required for Pre-School though Kindergarten and all new students.)

Name of Student_____ Date of Birth_____ Male☐ Female☐

Address_____
including City, State, Zip

Home Telephone Number (____)_____

Father or Guardian's Name_____

Mother's Name_____

EXAMINATION (Date of Examination_____)

Height_____ Weight_____ Allergies_____

Eyes_____ Ears_____ Referred to ear or eye specialist?_____

Dental Health_____ Orthopedic_____

Posture_____ Nervous System_____

Skin_____ Lungs_____

Neck_____ Hernia_____

Abdomen_____ Genitalia_____

Heart_____ General appearance_____

Nutrition_____ Blood lead level_____

Hemoglobin level_____

Remarks & recommendations (Under treatment? On medication? Standing orders? etc.):_____

_____

_____

RECORD OF IMMUNIZATIONS

	Date Given DTP	MMR	OPV / IPV Polio	Hib	Hep B	Other:_____
Diphtheria	①_____	Measles ①_____	①_____	①_____	①_____	①_____
Tetanus	②_____	Mumps ②_____	②_____	②_____	②_____	②_____
Pertussis	③_____	Rubella	③_____	③_____	③_____	③_____
	④_____		④_____	④_____		④_____
	⑤_____		⑤_____			

Varicella (Chicken Pox) vaccine_____ Tuberculin_____ DT_____

_____ | _____ | _____
Signature of Physician | Date | Phone Number

_____
Please print physician's name