MIRIAM ACADEMY
miriamacademy.org

MEDICAL EXAMINATION FORM

Child's Name:_____ **Birth date:**_____
Parent or Guardian:_____

CODE: **S** = Satisfactory **NS** = Not Satisfactory **O** = Not Examined

Height	Wgt	B.P.	Hgb	Urinalysis	Eyes

Nose	Hernia	Throat	Heart	Glasses	Skin

Teeth	Lungs	Hearing	Extremities	Abdomen

MEDICAL HISTORY: Allergy (Please Specify):_____

Chicken Pox_____ German Measles_____ Measles_____
Mumps_____ Recurrent Otitis_____ Recurrent Pneumonia_____
Surgery_____

Is the child on special medication? Yes_____ No_____
If yes, provide the type of medication, dosage and condition for which it is prescribed: _____

What side effects might be noticed? _____

Free from infectious disease? Yes_____ No_____
Any restrictions on activities? Yes _____ No_____
If yes, please specify: _____

Date of Examination:_____
Examining Physician _____
Physician's Address _____
_____
Phone #_____

Please return completed form to:

Miriam Academy, 2845 N. Ballas Road, St. Louis, MO 63131

THIS FORM MUST BE RETURNED TO THE SCHOOL OFFICE NO LATER THAN THE FIRST DAY OF SCHOOL