Jackson R-2 School District
Medical Examination Report

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH

☐ ARE ☐ ARE NOT SATISFACTORY FOR PARTICIPATION IN A SCHOOL PROGRAM.

III. COMMENTS/RECOMMENDATIONS/ABNORMAL FINDINGS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME OF CLINIC, GROUP PRACTICE, OTHER	IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME

ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )