PLAINVIEW-OLD BETHPAGE CENTRAL SCHOOL DISTRICT
PLAINVIEW, NEW YORK 11803

MEDICAL REPORT

Name_____ Date of Birth_____

Address_____

Phone_____

_____ _____
Signature of Applicant Date

Applicant:

1. Do you have or have you ever had: Chicken Pox ☐ Fifth's Disease ☐
   Measles ☐ German Measles ☐

2. Do you have or have you ever had:

Heart Disease ☐	Diabetes ☐	Anemia ☐
Hepatitis ☐	Asthma ☐	Tuberculosis ☐
Epilepsy/Seizure Disorder ☐	Any Surgery ☐	Any Hospitalization ☐

Please Explain Items Checked:

3. Have you traveled outside the United States since your last visit to a physician? Yes ☐ No ☐ Where_____

4. Are you or have you ever taken any daily medications for more that 14 days? Yes ☐ No ☐

   If yes, please list: _____

5. Do you have any medication allergies? Yes ☐ No ☐

   If yes, please list:_____

6. List the dates of your last: Chest X-Ray _____
   Tetanus Toxoid Immunization_____
   TB Skin Test _____ _____
   Tine Mantoux

7. Are you a smoker? ____ (Reply optional)

PHYSICIAN

Examination:

Appearance	_____			
Vital Signs	_____	BP:_____	Pulse:_____	Resp: _____
Skin	_____		Breasts	_____
Head	_____		Ext. Genitalia	_____
Eyes	_____		Back	_____
Nose	_____		Lymph Nodes	_____
Throat	_____		Extremities	_____
Neck	_____		Neurologic	_____
Lungs	_____		Teeth	_____
Heart	_____		Speech	_____
Abdomen	_____		Nutrition	_____

Physician's Comments:

Date of Examination_____

Physician's Name_____

Physician's Signature_____Date_____

Physician's Address_____