SCOTT COUNTY SCHOOL DISTRICT 2
MEDICAL AND DENTAL FORM

Student Name_____ **School**_____

Instructions to Parents: The school is advising that all beginning students have a physical, dental, and eye examination prior to entering school this August. Please make appointments with your family doctor, dentist and eye doctor. Take this form with you at the time of examination and make a copy for your records before giving it to the school.

Parents and guardians of students enrolling in school for the first time are required by Indiana law to furnish a written statement of the child's immunization history. Otherwise, your child will not be allowed to stay in school. ALL IMMUNIZATIONS SHOULD BE BROUGHT UP TO DATE **BEFORE** YOUR CHILD BEGINS SCHOOL.

IMMUNIZATION: **DATES-(Month, day and year)** ***May attach copy of shot record.***

Dtap _____ _____ _____ _____ _____ _____

Polio: IPV _____ _____ _____ _____ _____

MMR _____ _____

Hepatitis B _____ _____ _____

Hib _____ _____ _____ _____ _____

Varivax _____ _____ **or** **Date of chickenpox** _____

Other _____ _____ _____

Has testing for sickle cell anemia been done?_____ If yes, result_____
Has testing for lead poisoning been done?_____ If yes, result_____
Allergies:_____

Medical Exam/Nursing Assessment:
Height_____ Weight_____ Vision R_____ L_____
Hearing R____ L____ Skin and Scalp_____ Speech_____
Nervous System _____ Glands_____ Heart_____
Posture/orthopedic_____ Nutrition_____ Urine_____
Nasal Passages_____ Throat_____ Lungs_____
Comments/Recommendations:_____

DATE:_____ Physician Printed Name_____

Physician Signature_____ Phone_____

DENTAL EXAMINATION

Comments/Recommendations_____
_____

Date of exam_____ Dentist signature_____

SCOTT COUNTY SCHOOL DISTRICT 2
STUDENT VISION REPORT FORM

Student Name_____ Date_____

Date of Birth_____ Address_____
Parent/Guardian_____ School_____

Summary of Findings

1. Visual Acuity Pass Fail

Distance			**Near**	
Unaided	Rt. Eye 20/	Lt. eye 20/	Rt. Eye 20/	Lt. eye 20/
Corrected	Rt. Eye 20/	Lt. eye 20/	Rt. Eye 20/	Lt. eye 20/

2. Refractive Error Pass Fail Remarks_____
3. Ocular Health Pass Fail Remarks_____
4. Eye Muscle Balance Pass Fail Remarks_____
5. Binocular Depth Perception Pass Fail Remarks_____
6. Accommodation Pass Fail Remarks_____
7. Color Perception Pass Fail Remarks_____
8. Other_____

Analysis of Vision and Eye Health:_____
_____

Present Prescription Satisfactory _____ Vision Therapy Prescribed_____
Other (explain)_____
Contact Lens/Glasses: Should be worn (if prescribed):
Constant_____ Desk work only_____ Far vision only_____

Recommendations to classroom teacher:_____
_____

Reexamination advised in _____

I, being licensed to practice optometry and /or ophthalmology, certify that this student's vision and eye health have been examined by me and:
_____Are sufficient to enter kindergarten or
_____Appropriate treatment has been recommended for deficiencies in this student's vision or eye health.

Date:_____ Physician printed name:_____

Physician signature: _____

Phone:_____ Address:_____