Saydel Community Schools
Cornell Elementary
School Medical Report

To be completed by Physician, Nurse Practitioner or Physician Assistant

Student Name _____ **Date of Birth** _____ **Male/Female**
Parent/Legal Guardian Name _____ **Phone** _____
Physician's Name _____ **Phone** _____
Allergies: Medications_____
Foods_____Other_____
(For school lunch substitution, Physician must complete and sign Diet Modification Request)
Please attach current Iowa Certificate of Immunizations

	Normal ✓	Abnormal ✓	Comments – required for abnormal
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Endocrine			
Abdomen			
Nutritional Status			
General Appearance			
Development			
Other			

Height_____ Weight_____ BP_____ Hgb_____ Lead Screen_____/Date_____
Vision: Both 20/_____ Right 20/_____ Left 20/_____ Corrective lenses Y/N

Chronic Diseases _____

Medications _____

Surgeries/Hospitalizations/Serious injury _____

Physician Comments or Recommendations _____

_____

Physical Education Program: Full_____ Limited_____ None_____ Reason_____

Health Care Provider Signature _____ Exam Date_____