

STUDENT'S NAME _____

DENTIST'S REPORT

The following services have been performed:

(Please check)

- _____ radiographs
- _____ oral prophylaxis
- _____ fluoride treatment
- _____ restorations

The following statements are accurate:

(Please check)

- _____ all necessary services have been performed
- _____ no restorative services are required at this time
- _____ further treatment is indicated
- _____ future appointments have been arranged

Comments:

Date _____

Signature of examining physician

PHYSICIAN'S REPORT

IMMUNIZATIONS

	Date	Date	Date	Date	Date
DPT					
Td					
Polio Sabin (OPV or IPV)					
MMR					
Varicella (Chicken Pox)					
Hib					
Hepatitis B					
Other:					

SCREENING TESTS

	Date	Result
Muscle Balance		
Farsightedness		
Color		
Distance Acuity		Right Left
Hearing		

	Date	Test	Result
Tuberculin			

PHYSICAL ASSESSMENT

Check one:

_____ Entirely within normal limits

_____ Abnormalities as follows:

Is there any reason why the student cannot carry out a full program of school work?

Yes _____ No _____

Date _____

Signature of examining physician

COMPLETE BOTH SIDES

(This page revised 1/10)