TRIPLE C SCHOOL
74 Fairbanks Road, GT
P. O. Box 10498
Grand Cayman KY1-1005
CAYMAN ISLANDS
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MEDICAL EXAMINATION FORM

Name of Student_____ **Present Grade**_____

Date of Birth (day/month/year)_____ **Parent(s) Names** _____

Immunizations/Vaccinations – Please record dates as (dd/mm/yyyy):

*medical exemption (M) explain:_____

*conscientious/religious exemption (C) explain: _____

	#1	#2	#3	#4	#5
DTaP					
Adult Td					
Hib					
OPV/IPV					
HBV					
MMR					
Varicella					
BCG					
Other					

Allergies: _____

Current medications: _____

Has your child ever been hospitalized? When? _____

Where? _____ Why?_____

Personal history (Has your child ever had….) Circle Yes or No:

Chicken Pox	Yes	No	Migraine Headaches	Yes	No
Seizures	Yes	No	Bladder/Kidney Trouble	Yes	No
Asthma	Yes	No	Nosebleeds	Yes	No
Menstrual Problems	Yes	No	Vision Problems	Yes	No
ADHD/ADD	Yes	No	Hearing Problems	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Surgery	Yes	No	Other_____		

If yes to any of the above, please explain: _____

_____

_____

PHYSICAL EXAMINATION:

Weight:_____ **Height:** _____

Eyes: General condition _____

Does the child Wear Glasses Wear Contacts Reading Glasses Only

Needs no assistance with sight

Acuity: Without glasses R: 20/_____ L: 20/_____ With glasses: R: 20/_____ L: 20/_____

Ears: General condition _____

Hearing: R: _____ L:_____

Nose:_____

Mouth/Teeth: General condition _____

Speech: _____

Respiratory system: _____

Heart: General condition _____

Heart rate: _____ b/min Blood pressure: _____ / _____

Abdomen: _____

Musculoskeletal system:_____

Skin & Hair: _____

Central nervous system:_____

Genitourinary system: _____

Please explain any abnormality noted above, or comment on any observation made during the examination that is relevant to the child's physical condition, particularly as it applies to school attendance and performance.

_____

_____

_____

Please state below if any blood, urine, or stool tests were done or are recommended.

_____

Name of Clinic/Hospital: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Doctor's Name: _____

Doctor's Signature:_____ Date: _____