



P O R T L A N D A D V E N T I S T A C A D E M Y

Medical Examination Report

Student Name \_\_\_\_\_

Grade 9 10 11 12

Examination Date \_\_\_\_\_

1. Significant illnesses, accidents, operations, congenital defects, family history, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Emotional stability, mental illnesses, family history, etc.

\_\_\_\_\_  
\_\_\_\_\_

3. Please indicate below any positive findings on examination, or any handicapping disability, and describe fully.

|                    |                             |                                |       |
|--------------------|-----------------------------|--------------------------------|-------|
| Skin               | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Eyes               | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Ears               | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Nose/Throat        | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Mouth              | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Glands             | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Heart              | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Abdomen            | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Hernia             | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Extremities        | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Genito-Urinary     | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |
| Nutritional Status | <input type="checkbox"/> OK | <input type="checkbox"/> Other | _____ |

|         |         |         |
|---------|---------|---------|
| Vision  | R _____ | L _____ |
| Hearing | R _____ | L _____ |

4. Please specify any recommended limitations in academic or physical activity. If none, check "No limitations".  NO LIMITATIONS

\_\_\_\_\_  
\_\_\_\_\_

Examining Physician: \_\_\_\_\_

Signature

Print

Date