Iglesia Evangélica Menonita
ACADEMIA MENONITA
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rev. 11/17

Medical Examination

Student's name:____
First Surname (primer apellido) Second Surname (segundo apellido) Name

Date of Birth:____________________ Gender:______ Blood type:________
month/day/year M or F

Student's Medical History

	No	Yes		No	Yes		No	Yes		No	Yes
Tumors	☐	☐	Eye/Sight illness	☐	☐	Asthma	☐	☐	Meningitis	☐	☐
Hernia	☐	☐	Deafness	☐	☐	Short of breath	☐	☐	Kidney illness	☐	☐
Diphtheria	☐	☐	Ear-nose-throat illness	☐	☐	Severe headaches	☐	☐	Diabetes	☐	☐
Rheumatic Fever	☐	☐	Sinusitis	☐	☐	Dizziness/Imbalance	☐	☐	Hypoglycemia	☐	☐
Heart illness	☐	☐	Allergies	☐	☐	Seizures	☐	☐	Hemophilia	☐	☐
Stomach illness	☐	☐	Frequent colds	☐	☐	Epilepsy	☐	☐	Encopresis	☐	☐
			Genitourinary illness	☐	☐	Thyroids	☐	☐	Enuresis	☐	☐

Specify any other illnesses or conditions, present or past (if allergic, to what?), actual medical treatments/medications:

____

____

Surgical history (type and date):____

____

Physical Examination

Sight: see enclosed form

Illness evidences:

	No	Yes	Observations
Head/Neck	☐	☐	
Mouth	☐	☐	
Ear-nose-throat	☐	☐	
Speech Difficulty	☐	☐	
Chest and Lungs	☐	☐	
Heart	☐	☐	
Extremities	☐	☐	
Hernia	☐	☐	
Skin	☐	☐	
Scars (specify)	☐	☐	
Prothesis	☐	☐	

Required clearance for physical activity

☐ ☐ Is the student apt to perform the normal physical activity of a Physical Education class?
☐ ☐ Is the student apt to perform the rigorous exercise and training required in sport teams?

General observations: ____

Doctor's signature ____________________ Doctor's name ____________________

License number ____________________ Address ____________________

Examination date ____________________ ____________________

Student's Name:____ Grade:______________

EYESIGHT TEST

Visual accuracy:		Without Rx	Rx
	Right eye	20/ ______	20/______
	Left eye	20/ ______	20/______
	Both eyes	20/ ______	20/______

Color vision: _____Normal _____Deficient

Visual field: _____Normal _____Restricted

The evaluated student _____requires or _____does not require the use of glasses or contact lenses.

Observations:

____

____

____

____
Name of Professional Evaluator

____
Signature of Professional Evaluator

License number: ____________________

____
Date of Evaluation

Please include official office seal or presentation card

DOCTOR OR OFFICE
OFFICIAL SEAL

NOTE: This test can be performed by any medical doctor.

PO Box 70184
San Juan, Puerto Rico 00936
www.salud.gov.pr

CERTIFICADO DE EXAMEN ORAL

Nombre del menor Apellido Paterno / Apellido Materno / Nombre / Inicial	Sexo F / M	Edad	Grado que cursa

Dirección física	Dirección postal	Teléfonos ( ) ( )

Nombre del padre, madre o encargado	Relación con el menor

EXAMEN ORAL

☐ **SE REALIZÓ EVALUACIÓN ORAL**	**RECOMENDACIONES :**
Fecha: Día / Mes / Año	☐Cuidado dental regular de rutina
☐ Se ofreció orientación de prevención e higiene	☐Necesita tratamiento dental adicional al de rutina
☐ Se refirió al paciente para tratamiento	☐ **URGENTE**

CERTIFICACIÓN DEL PROVEEDOR

Certifico haber provisto las recomendaciones y servicios arriba indicados

Nombre del dentista	Número de licencia
Dirección del dentista	**Teléfonos** ( ) ( )
Firma	**Fecha** Día / Mes / Año

COALICIÓN DE SALUD ORAL
DE PUERTO RICO