



Ministry of Education

National Resource Centre for Inclusive Education

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Medical Examination Form

This form must be completed by a Medical Doctor

Name: _____ Date Of Birth: _____
 Height: _____ Blood Pressure: _____ Pulse: _____
 Weight: _____ Head circumference: _____

Are you the family Physicians: Yes No

Do you see this patient: Regularly Seldom Not at all

Sex: Male Female
 Race: Creole Mestizo Oriental Garifuna East Indian Other

Posture: Good Fair Scoliosis Lordosis Kyphosis
 Gait: Normal Abnormal
 Skin: Normal Abnormal Moist Rash
 Head: Symmetrical Asymmetrical
 Hair: Normal Fine Coarse Dry

Eyes: Normal Nystagmus Strabismus
 Exophthalmos Enophthalmos

Eardrums: Normal Injected Dull Perforation
 Nose: Normal Abnormal
 Tonsils: Present Absent
 Enlarged Scarred Infected
 Chest: Clear Rhonchi Wheezing
 Heart: Normal Enlarged Murmurs

Neck: Supple Resistant to flexion
 Lymph Nodes: Normal Enlarged
 Thyroid: Palpable Not palpable

Abdomen: Normal Abnormal
 Hernia: Absent Present
 Location: _____

Genitalia: Normal Anomalies

Extremities: Movement Symmetrical Limited Paralysis

Neurological:

Mark all that are NORMAL

	Left	Right
Reflexes		
Patellar	<input type="checkbox"/>	<input type="checkbox"/>
Achilles	<input type="checkbox"/>	<input type="checkbox"/>
Biceps	<input type="checkbox"/>	<input type="checkbox"/>
Supinator	<input type="checkbox"/>	<input type="checkbox"/>
Cremasteric	<input type="checkbox"/>	<input type="checkbox"/>

Please mark all areas checked in the examination or areas of Concern:

	Normal	Abnormal
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Cranial nerves	<input type="checkbox"/>	<input type="checkbox"/>
Olfactory (smell)	<input type="checkbox"/>	<input type="checkbox"/>
Oculomotor (loss of pupil movement: eye turned outward)	<input type="checkbox"/>	<input type="checkbox"/>
Trochlear (eyes turned up and in)	<input type="checkbox"/>	<input type="checkbox"/>
Trigeminal (muscles of mastication)	<input type="checkbox"/>	<input type="checkbox"/>
Abducens (internal strabismus)	<input type="checkbox"/>	<input type="checkbox"/>
Facial (wrinkling forehead, closing of plate)	<input type="checkbox"/>	<input type="checkbox"/>
Auditory (hearing)	<input type="checkbox"/>	<input type="checkbox"/>
Glossopharyngeal (difficulty swallowing; control of palate)	<input type="checkbox"/>	<input type="checkbox"/>
Vagus (vocal cords)	<input type="checkbox"/>	<input type="checkbox"/>
Spinal accessory (shrugging shoulders, rotating head)	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglossal (tongue deviation)	<input type="checkbox"/>	<input type="checkbox"/>

Please provide additional comments on areas of concern based on this examination

NOTES:

Signature of Medical Doctor

Date of Examination