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| Gobierno de  Córdoba | Certificado Único de Salud (C.U.S.) | | | | | esc3  Instituto  “**José Peña”** |
|  |  |  |  |  |
| **Ciclo Lectivo** |  | **Nivel** |  | **Grado/Curso** |

A LLENAR POR PROFESIONAL MEDICO MATRICULADO A NIVEL PROVINCIAL - **VALIDEZ POR 1 AÑO**.

PARA INGRESO ESCOLAR, ACTIVIDADES DE EDUCACION FISICA, NATACION, CURRICULARES Y EXTRA CURRICULARES.

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| **Fecha** |  |  |  |

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| **Apellido** | | | | | | | | | | | |  | **Nombre** | | | | | | | | | | | | |  | **Documento** | | | | | | | | |
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| **Fecha de Nacimiento** | | | | | | | | | |  | **Lugar de Nacimiento** | | | | | | | | | | | | | | | |  | **Edad** | | |  | **Sexo** | | | |
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| **Calle** | | | | | | | | | | | | | | | | | |  | **Numero** | | | |  | **Barrio** | | | | | | | | | | | |
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| **Teléfono Fijo** | | | | | | | |  | **Teléfono de la Madre** | | | | | | | |  | **Teléfono del Padre** | | | | | | | |  | **Teléfono de Emergencia** | | | | | | | | |

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| **Antecedentes** | | | | | | | | | | | | | | | | |
|  | **1** | **Vacunaciones** | | | | | | | | | | | | | | |
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|  |  |  | Carnet | | | | |  | |  | |  |  |  |  |  |
|  |  |  | Completo | | | | |  | |  | |  |  |  |  |  |
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|  |  | Debe completar esquema con | | | | | | | | | |  |  |  |  |  |
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|  | **2** | **Antecedentes Patológicos** | | | | | | | | | | | | | | |
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|  |  | Enfermedades Importantes | | | | | | | | |  |  |  |  |  |  |
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|  |  | Cirugías | | | | | |  |  |  |  |  |  |  |  |  |
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|  |  | Cardiovasculares | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | Trauma c/alt. func | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | Alérgicos(especif) | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | Oftalmológicos | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | Auditivos | | | | | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Diabetes | | | |  |  | |  | Asma | | | |  |  | |
|  |  | Chagas | | | |  |  | |  | Hipertensión | | | |  |  | |
|  |  | Neurológico | | | |  |  | |  |  |  |  |  |  |  |  |
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|  |  | Auditivos | | | | | |  |  |  |  |  |  |  |  |  |
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|  |  | **Examen Físico** | | | | | | | | | | | | | | |
|  |  | Peso | | | | |  |  | | |  |  |  |  |  |  |
|  |  | Talla | | | | |  |  | | |  |  |  |  |  |  |
|  |  | IMC | | | | |  |  | | |  |  |  |  |  |  |
|  |  | Diagnostico Antropométrico | | | | | | | | | |  |  |  |  |  |
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|  |  | **Examen Oftalmológico** | | | | | | | | | | | | | | |
|  |  | Agudeza Visual | | | | | | | | | |  |  |  |  |  |
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|  |  | Usa Anteojos | | | | | | | |  |  | |  |  | |  |
|  |  | Otros | | | | | | | |  |  | |  |  | |  |
|  |  | **Examen Fonoaudiológico** | | | | | | | | | | | | | | |
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|  |  | **Examen Piel y T.C.S.C.** | | | | | | | | | | | | | | |
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|  |  | **Examen Odontológico** | | | | | | | | | | | | | | |
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|  |  | **Examen Respiratorio** | | | | | | | | | | | | | | |
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|  |  | **Examen Cardiovascular** | | | | | | | | | | | | | | |
|  |  | Auscultación | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  | Arritmia | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  | Soplos | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  | Tensión Art. | | | | |  |  |  |  |  |  |  |  |  |  |

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|  | **3** | **Condiciones de Riesgo** | | | | | | | | | | | | | | |
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|  | **4** | **Medicamentos Prescriptos** | | | | | | | | | | | | | | |
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|  | **5** | **Durante Actividad Física Previa Sufrió** | | | | | | | | | | | | | | |
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|  |  | Cansancio extremo | | | | | | | |  |  | |  |  | |  |
|  |  | Falta de aire | | | | | | | |  |  | |  |  | |  |
|  |  | Pérdida de conocimiento | | | | | | | |  |  | |  |  | |  |
|  |  | Palpitaciones | | | | | | | |  |  | |  |  | |  |
|  |  | Precordalgias | | | | | | | |  |  | |  |  | |  |
|  |  | Cefaleas | | | | | | | |  |  | |  |  | |  |
|  |  | Vómitos | | | | | | | |  |  | |  |  | |  |
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|  |  | Otros | | | |  |  |  |  |  |  |  |  |  |  |  |
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|  |  | **Examen Abdomen** | | | | | | | | | | | | | | |
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|  |  | **Examen Genitourinario** | | | | | | | | | | | | | | |
|  |  | Menarca | | | | |  |  |  |  |  |  |  |  |  |  |
|  |  | Turner | | | | |  |  |  |  |  |  |  |  |  |  |
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|  |  | **Examen Endocrinológico** | | | | | | | | | | | | | | |
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|  |  | **Examen Osteoarticular** | | | | | | | | | | | | | | |
|  |  |  | | | | Nor. | |  | Cif | |  | Lord. | |  | Esc. | |
|  |  | Columna | | | |  | |  |  | |  |  | |  |  | |
|  |  | Miembros Sup | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | Miembros Inf. | | | | | |  |  |  |  |  |  |  |  |  |
|  |  | **Examen Neurológico** | | | | | | | | | | | | | | |
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|  |  | **Se indican Exámenes Complementarios y o Derivaciones** (Adjuntar Informes) | | | | | | | | | | | | | | |
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| **Grupo Sanguíneo** | | | | |
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| **SE RECOMIENDA** |
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Hago constar que \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ se encuentra en condiciones para el ingreso escolar, la realización de actividades físicas curriculares y lo establecido en la Resolución M.E. 57 de acuerdo al examen clínico actual y en reposo practicado en la fecha.

**Esta Documentación original debe permanecer en custodia y conservación legal de la Dirección del Centro Educativo, y la copia en poder del responsable legal del alumno.**

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| ***Lugar y Fecha*** |  | ***Firma y Sello del Medico*** |

**Notificado**

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| ***Firma del Alumno*** |  | ***Firma de la Madre*** |  | ***Firma del Padre*** |