STUDENT MEDICAL RECORD

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

Name _____ Birth Date _____

Address _____

_____

Name of Father _____ Name of Mother _____

History (past illnesses and allergies. Please check those he/she has had.)

- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Measles
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Ear Infections
- ☐ Other

Allergies:

- ☐ Asthma
- ☐ Hay Fever
- ☐ Insect Bites
- ☐ Penicillin
- ☐ Other Drugs

Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience.

_____

Indicate physical problem by check: Hearing ☐ Heart ☐ Sight ☐ Speech ☐

Other _____
SPECIFY

IMMUNIZATIONS – An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Records considered official are:

State Immunization Record
Health Provider Record – must have signature, stamp, or initials next to each date.
Physician's Record
County Health Department Record
Official Immunization Record from another state
School Immunization Record

LABORATORY RECORD

TB Screening ____/____/____ **TB Clearance** ☐ **Yes** ☐ **No - If no, a TB skin test is required**

	Type*	Dates Given	Given By	Date Read	Read By	Impression
TB SKIN TEST	☐ PPD Mantoux ☐ Other ____	/ / / /		/ / / /		☐ Positive ☐ Negative

CHEST X-RAY Film date: ____/____/____ Impressing: ☐normal ☐abnormal

Person is free of communicable tuberculosis ☐yes ☐no

Signature/Agency _____

PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	Explain Abnormalities
Skin	☐	☐	☐	_____
Eyes, vision, glasses	☐	☐	☐	_____
Ears, hearing	☐	☐	☐	_____
Nose and throat	☐	☐	☐	_____
Mouth, teeth, speech	☐	☐	☐	_____
Glands	☐	☐	☐	_____
Chest, lungs	☐	☐	☐	_____
Cardiovascular, heart	☐	☐	☐	_____
Abdomen, enlargement	☐	☐	☐	_____
tenderness	☐	☐	☐	_____
hernia	☐	☐	☐	_____
Spine, back	☐	☐	☐	_____
Scoliosis for Grade 7	☐	☐	☐	_____
Posture	☐	☐	☐	_____
Extremities	☐	☐	☐	_____
Genitourinary	☐	☐	☐	_____
Nervous System, reflexes	☐	☐	☐	_____

Nutritional status and general appearance of the child _____

_____

Recommendations for additional medical or dental care _____

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling. ☐ Yes ☐ No

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

_____

Date _____ Physician's Signature _____

Address _____

*To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at grade seven (this should include the scoliosis examination), c) at least once in grades nine through twelve, d) at other grades when required by the Conference Board of Education.