

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.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever | Allergies:
<input type="checkbox"/> Asthma
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Insect Bites
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Other Drugs |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ear Infections | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other | |
| <input type="checkbox"/> Measles | | |

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 SKIN TESTS	Type*		Dates Given	Given By	Date Read	Read By	Impression	
	<input type="checkbox"/>	PPD Mantoux					<input type="checkbox"/>	Positive
<input type="checkbox"/>	Other _____					<input type="checkbox"/>	Negative	
<input type="checkbox"/>	PPD Mantoux					<input type="checkbox"/>	Positive	
<input type="checkbox"/>	Other _____					<input type="checkbox"/>	Negative	
<input type="checkbox"/>	PPD Mantoux					<input type="checkbox"/>	Positive	
<input type="checkbox"/>	Other _____					<input type="checkbox"/>	Negative	

*If required by school entry, must be Mantoux unless exception granted by local health department

CHEST X-RAY	Film date: _____	Impressing: <input type="checkbox"/> normal <input type="checkbox"/> abnormal
	Person is free of communicable tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
	Signature/Agency _____	

PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, vision, glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose and throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth, teeth, speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular, heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen, enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine, back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis for Grade 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous System, reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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.