|  |
| --- |
| 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 | [ ]  | Rheumatic Fever | Allergies: |
|  | [ ]  | Chicken Pox | [ ]  | Scarlet Fever | [ ]  | Asthma |
|  | [ ]  | Diabetes | [ ]  | Tuberculosis | [ ]  | Hay Fever |
|  | [ ]  | Diphtheria | [ ]  | Whooping Cough | [ ]  | Insect Bites |
|  | [ ]  | Epilepsy | [ ]  | Ear Infections | [ ]  | Penicillin |
|  | [ ]  | Heart Disease | [ ]  | Other | [ ]  | Other Drugs |
|  | [ ]  | 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 RecordHealth Provider Record – must have signature, stamp, or initials next to each date. |
|  | Physician’s RecordCounty Health Department Record |
|  | Official Immunization Record from another stateSchool Immunization Record |
| **LABORATORY RECORD** |
|  | TBSKINTESTS | Type\* | Dates Given | Given By | Date Read | Read By | Impression |  |
|  | [ ] [ ]  | PPD MantouxOther       |            |            |            |            | [ ] [ ]  | PositiveNegative |  |
|  | [ ] [ ]  | PPD MantouxOther       |            |            |            |            | [ ] [ ]  | PositiveNegative |  |
|  | [ ] [ ]  | PPD MantouxOther       |            |            |            |            | [ ] [ ]  | PositiveNegative |  |
|  |  | \*If required by school entry, must be Mantoux unless exception granted by local health department |  |
|  |  |  |  |  |  |  |  |  |  |
|  | CHEST X-RAY  | Film date: |       | Impressing: | [ ]  | normal | [ ]  | abnormal |  |
|  |  | Person is free of communicable tuberculosis  | [ ]  | yes | [ ]  | no |  |
|  |  | Signature/Agency |  |  |  |
|  |  |  |

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|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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. |  |