EPHESUS JUNIOR ACADEMY

3700 Midlothian Turnpike • Richmond, VA 23224 • (804) 233-4582

STUDENT MEDICAL RECORD

***INSTRUCTIONS – Parents, complete this side of the form. Have your family physician complete the other side. All students in grades K4-8 must have a physical examination.**

LAST NAME _____ **FIRST NAME** _____ **MI** _____

BIRTH DATE _____/_____/_____ **SSN** _____-_____-_____ **GRADE** _____
MM DD YY

ADDRESS _____

_____

FATHER'S NAME _____

MOTHER'S NAME _____

HISTORY – Past illnesses and allergies. Please check all that apply.

ALLERGIES:	_____	CANCER:	_____	HEART DISEASE:	_____
ASTHMA:	_____	CHICKEN POX:	_____	MEASLES:	_____
HAY FEVER:	_____	DIABETES:	_____	RHEUMATIC FEVER:	_____
INSECT BITES:	_____	DIPTHERIA:	_____	SCARLET FEVER:	_____
PENICILLIN:	_____	EAR INFECTIONS:	_____	TUBERCULOSIS:	_____
OTHER DRUGS:	_____	EPILEPSY:	_____	WHOOPING COUGH:	_____

Explain briefly other factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, vision problems that may affect the child's school experience.

_____

_____

_____

IMMUNIZATIONS – Obtain immunization record from your child's physician. Submit with the registration package.

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PHYSICIAN'S EXAMINATION

STUDENT NAME _____

BLOOD PRESSURE _____ **HEIGHT** _____ **WEIGHT** _____

NUTRITIONAL STATUS AND GENERAL APPEARANCE OF CHILD _____

_____

RECOMMENDATIONS FOR ADDITIONAL MEDICAL/DENTAL CARE _____

_____

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

If the student must be restricted from participating in activities such as named above, please indicate physical activities that may be permitted: _____

_____

ORGAN/SYSTEM	NORMAL	ABNORMAL	NO EXAM	EXPLAIN ABNORMALITIES
Nervous system/reflexes				
Skin				
Eyes/ vision/ glasses				
Ears/ hearing				
Nose and throat				
Mouth/ teeth / speech				
Glands				
Cardiovascular/ heart				
Chest / lungs				
Abdomen / hernias				
Abdomen / tenderness				
Abdomen / enlargement				
Extremities				
Spine / back				
Scoliosis				
Posture				
Genitourinary				

DATE _____ **SIGNATURE** _____ **MD**

ADDRESS _____ **PHONE** _____

_____