Print Form

Medical Evaluation Record of Student
(With Physician's Recommendations)

The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.
(to be filled in by the physician)

Student's name: _____ Birthday: _____ Sex: ___
Address: _____ Father's name: _____
_____ Mother's name: _____
School: _____

Question	No	Yes	If yes, explain
I. A. Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma or other?	○	○	
B. Does student have other medical problem with which the school should be concerned?	○	○	
C. Is there evident need for dental care?	○	○	
D. Is there a hearing defect for which the school could help compensate by seating or other action?	○	○	
E1. Has the student had a vision screening test?	○	○	Date: Result:
E2. Are there ocular defects that indicate a need for referral to an eye doctor?	○	○	
E3. Are there any visual defects for which the school could help compensate by seating or some other action?	○	○	

II. Immunization is required by law. It is expected that the physician will administer whatever inoculations are indicated at the time of this examination and record these and other previous inoculations.

Please attach a copy of the immunization record for our files.

III. Have there been any illnesses, accidents, operations, or congenital defects that limit the student's participation in:

Classroom activities? ○Yes ○No Physical education activities? ○Yes ○No Swimming? ○Yes ○No

If so, explain: _____

IV. Is there any mental, emotional, or physical condition, for which the student should remain under your periodic observation?
○Yes ○No If Yes, explain: _____
_____
At what interval does the student need rechecks? _____

V. Physician's recommendation to school: _____
_____
_____

I would like the □ **nurse** □ **teacher** to contact me regarding this student _____

Date of examination: _____ Signature: _____

Office Address: _____ Telephone: _____
Street City State Zip

Prepared by the General Conference Department of Health and Education

Health Inventory

(to be filled in by parent, before examination by physician)

1. Name of Student: _____ Age: _____ Birthdate: _____
Address: _____ Telephone: _____
Father's name: _____ Mother's name: _____

Whom to notify in case of illness (give addresses and phone numbers)

_____ _____

_____ _____

Does student live at home with parent? ☐ Mother ☐ Father ☐ Other _____

Does student have coverage by accident or hospitalization policy? (state type) _____

2. Past illnesses (please check those student has had)

☐ Measles	☐ Scarlet fever	☐ Heart disease
☐ Whooping cough	☐ Diphtheria	☐ Chorea (St. Vitus' Dance)
☐ Polio	☐ Chickenpox	☐ Epilepsy
☐ Rheumatic fever	☐ Diabetes	☐ Frequent colds (No. per year)
		☐ Hay fever or asthma

List any other serious illnesses, operations or injuries, and age when occurred.

3. Has this student ever been around anyone known to have tuberculosis? ◯ Yes ◯ No

Has he/she ever been skin tested for tuberculosis? Year _____ ◯ Yes ◯ No

Has he/she ever had a chest X-ray? Year _____ ◯ Yes ◯ No

4. When did the child last visit the dentist? (Recommend visit twice yearly) Date: _____

5. Has the student has his/her eyes examined? Date: _____
By whom? _____

6. Comment on student's habits:

How many hours of sleep does he/she usually get each night? _____

Does he/she participate in outdoor sports? ◯ Not at all ◯ Moderately ◯ Continuously

Does he/she prefer reading or watching TV to the above? ◯ Yes ◯ No

Eating habits: ◯ Eats only at mealtimes ◯ In between meals occasionally ◯ Frequently

7. List any other items helpful to the school program in planning for student's health:

Date: _____ Signature of Parent: _____