

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 _____

_____ Social Security Number _____

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 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"/> Other _____	/ /		/ /		<input type="checkbox"/> Neg	
<input type="checkbox"/> PPD Mantoux	/ /		/ /		<input type="checkbox"/> Pos	
<input type="checkbox"/> Other _____	/ /		/ /		<input type="checkbox"/> Neg	
<input type="checkbox"/> PPD Mantoux	/ /		/ /		<input type="checkbox"/> Pos	
<input type="checkbox"/> Other _____	/ /		/ /		<input type="checkbox"/> Neg	

*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 _____

PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	
Skin				Explain Abnormalities _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
Eyes, vision, glasses				
Ears, hearing				
Nose and throat				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen, enlargement				
tenderness				
hernia				
Spine, back				
Scoliosis				
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 five, c) at least once in grades nine through twelve, and d) at other grades, when required by the Conference Board of Education.