Fresno Adventist Academy

Student Medical Record

Only designated staff, such the school nurse or physician, will have access to the completed form.
This form will be stored in a locked file.

Student Name _____

Address _____
Street City State Zip

Birth date _____ Social Security Number_____
Month / Day / Year

Father/Guardian's Name _____

Mother/Guardian's Name _____

History: (Past illnesses and allergies. Please check those he/she has had.)

- ❒ Cancer
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Diphtheria
- ❒ Epilepsy
- ❒ Heart Disease
- ❒ Measles
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Tuberculosis
- ❒ Whooping Cough
- ❒ Ear Infections
- ❒ Other _____

Allergies:

- ❒ Asthma
- ❒ Hay Fever
- ❒ Insect Bites
- ❒ Penicillin
- ❒ Other Drugs _____

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

Date of last tetanus shot: _____

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

	Type *	Dates Given	Given by	Date Read	Read By		Impression
TB SKIN TESTS	❒ PPD Mantoux						❒ Pos
	❒ Other _____						❒ Neg
	❒ PPD Mantoux						❒ Pos
	❒ Other _____						❒ Neg
	❒ PPD Mantoux						❒ Pos
	❒ Other _____						❒ 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_____

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Fresno Adventist Academy

PHYSICIAN'S EXAMINATION*

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 this school for the first time, b) at seventh grade (this should include the scoliosis examination), c) at least once in grades nine through twelve, and d) when required by the Conference Board of Education.*

Please turn over ➢

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Fresno Adventist Academy

Sports Physical

Central California Conference of Seventh-day Adventists
Friendship Games Commission
California Interscholastic Federation

To Parents/Guardians:

This form must be completed before an athlete can participate in interscholastic practice, tryouts or contests. Your cooperation is appreciated.

Rico Balugo, Sports Ministry Director

TO BE COMPLETED BY THE STUDENT & PARENT

Student's Legal Name:_____ Date of Birth _____
First Middle Name Last

Grade Level for the school year 20___- 20___ (Circle one) 5th 6th 7th 8th 9th 10th 11th 12th

Please check the following sports in which you have interest in:

- ❑ Flag Football
- ❑ Basketball
- ❑ Track & Field
- ❑ Softball
- ❑ Volleyball
- ❑ Soccer
- ❑ Golf
- ❑ Running

TO BE COMPLETED BY THE DOCTOR

_____ I hereby certify that I have examined the above-named student and there appears to be no medical reason why he/she is not able to compete in the supervised interscholastic activities checked below.

- ❑ Flag Football
- ❑ Basketball
- ❑ Track & Field
- ❑ Softball
- ❑ Volleyball
- ❑ Soccer
- ❑ Golf
- ❑ Running

Doctor's Name _____ Phone: _____

Address_____

City/State/Zip_____

Doctor Signature_____ Date _____

Signature of Parent/Guardian_____ Date _____

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