



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	<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
	<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.

Film date: _____ / _____ / _____ Impressing: normal abnormal

CHEST Person is free of communicable tuberculosis yes no

X-RAY Signature/Agency _____



PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined
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			

Explain Abnormalities

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 ➤