



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

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

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"/> Chicken Pox   | <input type="checkbox"/> Scarlet Fever   |            | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Tuberculosis    |            | <input type="checkbox"/> Hay Fever    |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> Whooping Cough  |            | <input type="checkbox"/> Insect Bites |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Ear Infections  |            | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other           |            | <input type="checkbox"/> Other Drugs  |
| <input type="checkbox"/> Measles       |  |            |                                       |

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

**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

**TB testing** for children is no longer required by the state of CA for school entry. If TB risk factors or TB symptoms are identified in some students, the school may require that student to get TB screening.

*Optional:*

TB Screening for Risk Factors: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_ No Risk Factors – no further testing required

\_\_\_\_\_ Yes, Risk Factors present



### PHYSICIAN'S EXAMINATION\*

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

	Normal	Abnormal	Not Examined	Explain Abnormalities
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, vision, glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose and throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth, teeth, speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular, heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen, enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine, back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis for Grade 7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nervous System, reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 seven (this should include the scoliosis examination), c) at least once in grades nine through twelve