

# 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 \_\_\_\_\_

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:<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Hay Fever<br><input type="checkbox"/> Insect Bites<br><input type="checkbox"/> Penicillin<br><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 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

**LABORATORY RECORD**

| TB<br>SKIN<br>TESTS      | Type*                    |             | Dates Given | Given By | Date Read | Read By | Impression               |                          |
|--------------------------|--------------------------|-------------|-------------|----------|-----------|---------|--------------------------|--------------------------|
|                          | <input type="checkbox"/> | PPD Mantoux |             |          |           |         |                          | <input type="checkbox"/> |
| <input type="checkbox"/> | Other _____              |             |             |          |           |         | <input type="checkbox"/> | Negative                 |
| <input type="checkbox"/> | PPD Mantoux              |             |             |          |           |         | <input type="checkbox"/> | Positive                 |
| <input type="checkbox"/> | Other _____              |             |             |          |           |         | <input type="checkbox"/> | Negative                 |
| <input type="checkbox"/> | PPD Mantoux              |             |             |          |           |         | <input type="checkbox"/> | Positive                 |
| <input type="checkbox"/> | Other _____              |             |             |          |           |         | <input type="checkbox"/> | Negative                 |

\*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   | <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, d) at other grades when required by the Conference Board of Education.