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. Parents fill out top front page, Doctor fills out bottom and back page.

Name____ Birth Date ____________________

Address ____

____

Name of Father____________________________ Name of Mother________________________________

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

- ❒ Cancer
- ❒ Chicken Pox
- ❒ Diabetes
- ❒ Diptheria
- ❒ 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

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 TEST REQUIRED ONLY IF YOUR CHILD IS ENTERING /TRANSFERRING FROM OUT OF CALIFORNIA**

	Type*	Dates Given	Given by	Date Read	Read By		Impression
TB SKIN TESTS	❒ PPD Mantoux ❒ Other______	/ / / /		/ / / /			❒ Pos ❒ Neg
	❒ PPD Mantoux ❒ Other______	/ / / /		/ / / /			❒ Pos ❒ Neg
	❒ PPD Mantoux ❒ Other______	/ / / /		/ / / /			❒ Pos ❒ 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 is communicable tuberculosis ❒ yes ❒ no

Signature/Agency ____

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 (7th Grade Req.)				
Posture				
Extremities				
Genitourinary				
Nervous System, reflexes				

Nutritional Status and general appearance of the child ______________________________

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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, and d) at other grades, when required by the Conference Board of Education.