STUDENT MEDICAL RECORD
2022-2023

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 ____

____ Social Security Number ________________

Name of Father __________________________ Name of Mother ______________________________

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

❒ Cancer	❒ Rheumatic Fever	Alergies:
❒ Chicken Pox	❒ Scarlet Fever	❒ Asthma
❒ Diabetes	❒ Tuberculosis	❒ Hay Fever
❒ Diptheria	❒ Whooping Cough	❒ Insect Bites
❒ Epilepsy	❒ Ear Infections	❒ Penicillin
❒ Heart Disease	❒ Other	❒ Other Drugs
❒ 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.
  - Physicians 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 ❒ 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 of 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 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 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.