STUDENT'S MEDICAL RECORD

Name _____ Birthdate _____

Address _____

_____ Social Security Number _____

Name of Father _____ Name of Mother _____

School _____ Grade _____

History of Past Illnesses and Allergies (please check those that apply):

Cancer	____	Measles	____	Ear infections	____
Chicken Pox	____	Rheumatic Fever	____	Allergies, asthma	____
Diabetes	____	Scarlet Fever	____	hay fever	____
Diphtheria	____	Tuberculosis	____	insect bits	____
Epilepsy	____	Whooping cough	____	penicillin	____
Heart disease	____	Other	____	Other drugs	____

Briefly explain factors such as surgeries, serious accidents or injuries, congenital defects, speech defects and/or vision problems which may affect the child's school experience:

_____

_____

_____

Immunizations – The following items should be filled out according to your state and local county health regulations:

DPT SERIES	DATE	PROVIDER's SIGNATURES
DPT I		
DPT II		
DPT III		
DPT BOOSTER		
DT BOOSTER		
DT BOOTER		

POLOP SERIES	DATE	PROVIDER's SIGNATURES
POLIO I		
POLIO II		
POLIP III		
POLIO BOOSTER		
POLIO BOOSTER		

PHYSICAL 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 *(Applicable to Grade 7)*				
Posture				
Extremities				
Genitourinary				
Nervous System, Reflexes				

Nutritional status and general appearance of the child _____

_____

This student may participate in a normal Physical Education (PE) Program which includes such activities as running, jumping and tumbling: Yes _____ No _____

If the student must be restricted from participating in activities such as listed above, please indicate the physical activities in which the student may participate:

_____

_____

Date _____ Physician's Signature: _____

Address _____

_____