STUDENT MEDICAL RECORD

STUDENT INFORMATION

Name _____ Date of Birth _____

Address _____ Mother's Name _____

City, State, Zip _____ Father's Name _____

PERSONAL HISTORY – (*Please check the illness the student has experienced.)*

- ☐ Asthma
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diptheria
- ☐ Ear Infection
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough /Pertusis
- ☐ Other_____

ALLERGIES – *(Please list any known allergies.)*

_____

_____

OTHER FACTORS – *(Briefly explain any factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, or vision problems which may affect the child's school experience.)*

_____

_____

TUBERCULOSIS ASSESSMENT

	Date Given *(day/mo/yr)*	mm indur	Impression	
TB Skin Test *(list most recent test & result)*			☐ Pos	☐ Neg
			☐ Pos	☐ Neg
Chest X-Ray *(required if skin test is positive)*	Film Date *(day/mo/yr)*	Impression ☐ Normal ☐ Abnormal		

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. Accepted official records include:

- California State Immunization Record ("yellow card")
- Health provider record (with signature, stamp, or initials next to each date)
- Official immunization record from another state
- California School Immunization Record (CSIR or "blue card")

PHYSICAL EXAMINATION – *(To be completed by the family physician and kept on file at the school.)*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	Explain Abnormalities
Eyes, Vision, Glasses				
Ears, Hearing				
Nose and Throat				
Mouth, Teeth, Speech				
Glands				
Chest, Lungs				
Cardiovascular, Heart				
Abdomen, enlargement				
Abdomen, tenderness				
Abdomen, hernia				
Spine, Back				
Scoliosis				
Posture				
Extremities				
Genitourinary				
Nervous System, Reflexes				

Nutritional Status and General Appearance of the Child / Youth: _____

_____

Recommendations for Additional Medical, Vision, or Dental Care: _____

_____

This student may participate in a normal physical education program which includes such activities as running, jumping, and tumbling.

☐ Yes ☐ No. If no, please explain: _____

_____

_____ _____ _____

Physician's Printed Name Physician's Signature Date

_____

Address – *(Street, City, State & Zip)*