



## 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.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Scarlet Fever            |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Hay Fever       | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Whooping Cough /Pertusis |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Measles         | <input type="checkbox"/> Other _____              |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> Mumps           |   |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Rheumatic Fever |   |

### 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 ( <i>day/mo/yr</i> )	mm	indur	Impression	
TB Skin Test <i>(list most recent test &amp; result)</i>				<input type="checkbox"/> Pos	<input type="checkbox"/> Neg
				<input type="checkbox"/> Pos	<input type="checkbox"/> Neg
Chest X-Ray <i>(required if skin test is positive)</i>	Film Date ( <i>day/mo/yr</i> )	Impression <input type="checkbox"/> Normal <input type="checkbox"/> 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.)

	Weight		Not Examined	Blood Pressure
	Normal	Abnormal		
Eyes, Vision, Glasses				Explain Abnormalities
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)