

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.

Name: _____ Birth Date (mm/dd/yy): _____

Address: _____

Name of Father: _____ Name of Mother: _____

Health History: (Past illnesses and allergies. Please place an "X" by those who he/she/has had.)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Scarlet Fever	Allergies:
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Insect Bites
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Measles		<input type="checkbox"/> Other: _____
<input type="checkbox"/> Rheumatic Fever		

Explain briefly any factors such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience:

Indicate any Physical problem: Hearing _____ Heart _____ Sight _____
Speech _____ Other: _____

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. Record 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 Immunizations Record from another state
- School Immunization Record

**Any new student must provide a copy of his/her birth certificate
PRIOR to final registration in August!**

