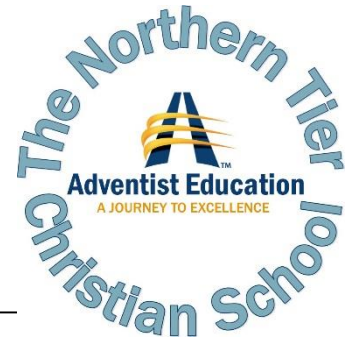


# STUDENT MEDICAL RECORD

Only designated staff will have access to the completed form.



Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Name of Father \_\_\_\_\_

Name of Mother \_\_\_\_\_

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

- |                                        |                                          |            |
|----------------------------------------|------------------------------------------|------------|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Rheumatic Fever | Allergies: |
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Scarlet Fever   |            |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Tuberculosis    |            |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> Whooping Cough  |            |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Ear Infections  |            |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____     |            |
| <input type="checkbox"/> Measles       | _____                                    |            |

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

\_\_\_\_\_  
\_\_\_\_\_

Indicate physical problems by checking box:

- Hearing    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. Records considered official are: Pennsylvania State Immunization Record.

## LABORATORY RECORD

	Type*	Date Given	Given By	Date Read	Read By	Impression
TB SKIN TESTS	<input type="checkbox"/> PPD Mantoux <input type="checkbox"/> Other _____					<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	<input type="checkbox"/> PPD Mantoux <input type="checkbox"/> Other _____					<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	<input type="checkbox"/> PPD Mantoux <input type="checkbox"/> Other _____					<input type="checkbox"/> Positive <input type="checkbox"/> Negative

\*If required by school entry, must be Mantoux unless exception granted by local health department.

**CHEST X-RAY** Film date \_\_\_\_\_ Impression:  Normal    Abnormal  
 Person is free from communicable tuberculosis:    Yes    No  
 Signature \_\_\_\_\_ Agency \_\_\_\_\_

## PHYSICAL EXAMINATION

To be completed by the family physician and kept on file at the school for all children entering school for the first time.

Student's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

	Normal	Abnormal	Not Examined	Comments
Skin				
Eyes, vision, glasses				
Ears, hearing				
Nose, throat				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen - enlargement - tenderness - hernia				
Spine, back Scoliosis for 7 <sup>th</sup> grade				
Posture				
Extremities				
Genitourinary				
Nervous system, reflexes				

Nutritional status and general appearance of child \_\_\_\_\_

Recommendations for additional medical care \_\_\_\_\_

This student may participate in a normal physical education program which includes such activities as running, jumping, and tumbling.  Yes  No  Limited Participation

Please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_