Ridgecrest Adventist Elementary

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 ______________

Address ____

____

Name of Father ____________________ Name of Mother ____________________

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

☐ Cancer	☐ Rheumatic Fever	☐ Allergies:
☐ Chicken Pox	☐ Scarlet Fever	☐ Asthma
☐ Diabetes	☐ Tuberculosis	☐ Hay Fever
☐ Diptheria	☐ Whooping Cough	☐ Insect Bites
☐ Epilepsy	☐ Ear Infections	☐ Penicillin
☐ Heart Disease	☐ Other	☐ Other Drugs
☐ Measles		

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

Indicate physical problem by check: Hearing ( ) Heart ( ) Sight ( ) Speech ( )

Other ____
SPECIFY

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:

State Immunization Record
Health Provider Record - must have signature, stamp, or initials next to each date.
Physician's record
County Health Department Record
Official Immunization Record from another state
School Immunization Record

	Type*	Dates Given	Given by	Date Read	Read By		Impression
TB SKIN TESTS	☐ PPD Mantoux ☐ Other						☐ Pos ☐ Neg
	☐ PPD Mantoux ☐ Other						☐ Pos ☐ Neg
	☐ PPD Mantoux ☐ Other						☐ Pos ☐ Neg

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

CHEST X-RAY Film date: ____/____/____ Impressing: ☐normal ☐abnormal

Person is free is communicable tuberculosis ☐yes ☐no

Signature/Agency ______________________________

PHYSICIAN'S EXAMINATION*

Height ________________ Weight ____________________ Blood Pressure ________________________

	Normal	Abnorm	Not Examin	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 for Grade 7				
Posture				
Extremities				
Genitourinary				
Nervous System, reflexes				

Nutritional Status and general appearance of the child ________________________________

Recommendations for additional medical or dental care ________________________________

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.
O yes O no

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

____

Date ____________________ Physician's Signature________________________________

Address ________________________________

* To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at grade seven (this should include the scoliosis examination), c) at least once in grades nine through twelve, and d) at other grades, when required by the Conference Board of Education.

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