Mountain View Academy
Christ-Centered College Preparatory Grades 9-12

360 S. Shoreline Blvd.
Mountain View, CA 94041
650-967-2324 (Ph) - 650-336-0053 (Fax)
www.mountainviewacademy.org

PHYSICIAN'S EXAMINATION*

Student Name: _____ Height _____ Weight _____ Blood Pressure _____

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. Yes ____ No ____

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

_____

Date _____ Physician's Signature _____

Address _____ City _____ State _____ Zip _____

*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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STUDENT MEDICAL RECORD

Name _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone # _____ Social Security # _____

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
	Diphtheria		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 student's school experience _____

_____

Indicate physical problems by checking: 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

LABORATORY RECORD

	Type *	Dates Given	Given/Read by:	Date Read	Impression
TB SKIN TESTS	PPD Mantoux	/ /		/ /	__ Pos
	Other _____	/ /		/ /	__ Neg
	PPD Mantoux	/ /		/ /	__ Pos
	Other _____	/ /		/ /	__ Neg
	PPD Mantoux	/ /		/ /	__ Pos
	Other _____	/ /		/ /	__ Neg
CHEST X-RAY	Film Date: _____/_____/_____ Impressing: ___ Normal ____ Abnormal Person is free from communicable tuberculosis ____ yes ____ no Signature/Agency _____				