



### 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.

### 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.)

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

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
CHEST X-RAY	PPD Mantoux	/ /		/ /	__ Pos
	Other _____	/ /		/ /	__ Neg
	Film Date: _____ / _____ / _____		Impressing: __ Normal __ Abnormal		
	Person is free from communicable tuberculosis __ yes __ no				
	Signature/Agency _____				