

# 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 \_\_\_\_\_

\_\_\_\_\_ Social Security Number \_\_\_\_\_

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

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

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

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

## LABORATORY RECORD

	Type*	Dates Given	Given by	Date Read	Read By		Impression
<b>TB SKIN TESTS</b>	<input type="checkbox"/> PPD Mantoux	/ /		/ /			<input type="checkbox"/> Pos
	<input type="checkbox"/> Other_____	/ /		/ /			<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD Mantoux	/ /		/ /			<input type="checkbox"/> Pos
	<input type="checkbox"/> Other_____	/ /		/ /			<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD Mantoux	/ /		/ /			<input type="checkbox"/> Pos
	<input type="checkbox"/> Other_____	/ /		/ /			<input type="checkbox"/> Neg

\*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 is communicable tuberculosis     yes     no

Signature/Agency \_\_\_\_\_

