STUDENT MEDICAL RECORD

Name			Birth Date	SSN
Address				
			of Mother	
School			Grade _	
HISTORY Past illnesses and allergies. Please check those he/she has had.				
Cancer	Me	easles		Ear Infections
Chicken Pox				Allergies, asthma
Diabetes	Coorlet Forcer			hay fever
Diptheria	Tuberculosis			insect bites
Epilepsy				penicillin
Heart disease	Other			other drugs
Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, vision problems, which may affect the child's school experience.				
* Please attach current immunization card with this form before submitting to the school.				
	PHYS	SICIAN'S	EXAMINATI	ON
Height	Weight			Blood Pressure
AREA	NORMAL	ABNORMAL	NOT EXAMINED	Explain Abnormalities
Skin				,
Eyes, Vision, Glasses				
Ears, Hearing				
Nose, 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 student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted				
Date	Signed			
	Address		(Physician)

^{*} 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 grade nine through twelve, d) at other grades, when required by the Conference Board of Education.