CONFIDENTIAL MEDICAL REPORT FOR STUDENTS

Academic Year (please circle): 2018 2019 2020

TO BE COMPLETED BY PARENTS

Child's Name:

Date of Birth:

Sex: ☐ Male ☐ Female

Mother's Name

Father's Name:

Primary Physician:

Child's Dentist:

Dentist's Office Number:

Office Location:

Doctor's Telephone Numbers:

THIS SECTION MUST BE COMPLETED BY CHILD'S PERSONAL PHYSICIAN

Immunization Record - (dd/mm/yy)

IMMUNIZATIONS	1st	2nd	3rd	1st BOOSTER	2nd BOOSTER
D.P.T.					
POLIO					
M.M.R.					
HIB VACCINE					
B.C.G.					
DTaP					
HEPATITIS B					
PREVNAR					
VARICELLA					
MANTOUX SKIN TEST (if advised by Pediatrician)					

Physical Examination

Height: _____ Weight: _____lbs. Blood Pressure ____/____

Posture _____ Hair_____ Skin _____

Ears _____ Nose _____ Throat_____

Gums _____ Tongue _____ Neck_____

Abdomen_____ Reflexes _____ Deformities_____

Lungs _____ Heart _____ Genitals: _____

	Yes	No		Yes	No		Yes	No
Seizures			Sickle Cell			Asthma		
Tonsillitis			Fainting Spells			Hepatitis		
Skin Problems			Pneumonia			Tuberculosis		
Diabetes			Chicken Pox			Worms		
ADH/D			H.I.V./A.I.D.S			Cancer		
Hearing Problems			Leukemia			Meningitis		
Vision Problems			Heart Problems					

Allergies (including allergies to medications): Yes No

If Yes, please state: _____

Child's general health status: Excellent Good Poor

Is this child physically fit for physical education classes?

Please list any physical education restrictions:

Is this child under special medical care?

Please list any surgeries and approximate dates:

Medications:

Does this child have *any* developmental delays/learning differences that the school should be aware of? If yes, please state below:

Physician's Signature:_____ Date: _____

Physician's Office Stamp Here:

THIS SECTION MUST BE COMPLETED BY CHILD'S PARENTS

Child's Behavior: socially well adjusted shy or withdrawn fights/hits/bites

Does your child have any emotional problems that the should be aware of? If yes, please explain below.

Insurance Information

Is the child covered by health insurance: Yes No

If yes, name of insurance company

Group number

Policy Number

Emergency Contacts (other than parents):

Name:

Relationship to child:

Please list at least three telephone contacts:

In the event of a medical emergency where hospital care is needed, which hospital should your child be taken to?

Doctor's Hospital Princess Margaret Hospital (PMH)

Does your family have religious restrictions to medical care? If yes, please state below.

Parent's Signature: _____

Date: