MEDICAL FORM

CONFIDENTIAL MEDICAL REPORT FOR NEW STUDENTS

Academic Year _____

THIS SECTION MUST BE COMPLETED BY CHILD'S PARENTS

PERSONAL INFORMATION

Child's Name :

Gender : Male Female **Date Of Birth :** D D M M Y Y

Mother's Name

Father's Name

Primary Physician **Telephone Number**

Child's Dentist **Telephone Number**

Child's Behavior: socially well adjusted shy or withdrawn fights/hits/bites

Does your child have any emotional problems that the school should be aware of? Yes No

If yes, please explain below.

_____

Insurance Information

Is the child covered by health insurance: Yes No

If yes, name of the insurance company

Group number **Policy Number**

MEDICAL FORM

THIS SECTION MUST BE COMPLETED BY CHILD'S PERSONAL PHYSICIAN

IMMUNIZATION RECORD

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:** _____ **Posture:** _____ **Blood Pressure:** _____

Ears: _____ **Hair :** _____ **Nose:** _____ **Skin:** _____

Gums: _____ **Throat:** _____ **Neck:** _____ **Tongue:** _____

Abdomen: _____ **Lungs:** _____ **Heart:** _____ **Genitals:** _____

Reflexes: _____ **Deformities:** _____

	Yes	No		Yes	No		Yes	No
Seizures			Asthma			Meningitis		
Tonsillitis			Tuberculosis			Hepatitis		
Skin			Pneumonia			Worms		
Diabetes			Chicken Pox			Cancer		
ADHD			HIV./AIDS			Other: _____		
Sickle Cell			Leukemia					
Fainting Spells			Heart Condition					

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Allergies (including allergies to medications): ☐ **Yes** ☐ **No**

If Yes, please state: _____

Does this child have an EpiPen? ☐ **Yes** ☐ **No**

If Yes, please provide further details:

_____

Child's general health status: **Excellent** **Good** **Poor**

Is this child physically fit for physical education classes? ☐ **Yes** ☐ **No**

Please list any physical education restrictions:

_____

Is this child under special medical care? ☐ **Yes** ☐ **No**

Please list any surgeries and approximate dates:

_____

Medications: _____

Does this child have any developmental delays/learning differences, including Autism, that the school should be aware of? ☐ **Yes** ☐ **No**

If yes, please state below:

_____

Physician's Office Stamp Here:

Physician's Signature:_____

Date: _____