MEDICAL EVALUATION RECORD OF STUDENT

(WITH PHYSICIANS RECOMMENDATIONS)

The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.

Students name_____ Birth Date___/____/_____ Sex: Male Female
Address
Father's Name Mother's Name
School's Name

I. A. Is the student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other? Yes/No (circle one) If yes, please explain _____

B. Does student have any other medical problem with which the school should be concerned? Yes/No (circle one) If yes, please explain:_____

II. Immunization is required by law. It is expected that the physician will administer whatever inoculations are indicated at the time of this examination and record these and other previous inoculations:

A. Immuniztion Tests

Primary		Last Booster	Primary		Last Booster
Year completed		Date	Year completed		Date
	Whooping Cough			Measles	
	Diphtheria			Rubella	
	Tetanus			Sickle Cell	
	Polio			Other	
	Smallpox			Other	

B. TUBERCULIN TEST: TYPE:
DATE: RESULT:

C. Is there evident need for dental care? ____Yes ____No

D. Is there a hearing defect for which the school could help compensate by seating or other actions? ____Yes ____No

E. 1. Has the student had a vision screening test? ___Yes ____No Date _____ Result _____

2. Are there ocular defects that indicate need for referral to an eye doctor? ____Yes ____No

3. Are there any visual defects for which the school could compensate by seating or other action? ____Yes ____No

I. Have there been any illnesses, accidents, operations, or congenital defects that limit the students participation in:
Classroom Activities? Yes/No Physical Education? Yes/No Swimming? Yes/ No
If yes, explain

IV. Are there any mental, emotional or physical conditions for which the student should remain under your periodic observation? Yes/No If yes, explain

At what interval(s) does the student need rechecks?

V. Physicians Recommendations to the school:
_____ I would like the school to contact me regarding this student.

Date of examination:_____ Signature of Physician:_____

Office Address: _____ Telephone:_____

Health Inventory

(To be filled in by parent BEFORE examination by Physician)

Name of Student: _____ Age ____ Date of Birth: _____
Address: _____ Telephone:_____
Father's Name: _____Mother's Name: _____
Whom to notify in case of illness(give Names, Addresses, Telephone numbers):
Name: _____ Name: _____
Address: _____ Address: _____
Phone Number: _____ Phone Number: _____

Does student live at home with parents? ____ Mother _____ Father Other: _____
Does student have coverage by accident or hospitalization policy?
(State Type) _____

Past illnesses (please check those the student has had)

Measles	Scarlet Fever	Heart Disease
Whooping Cough	Diphtheria	Chorea (St. Vitus Dance)
Polio	Chickenpox	Epilepsy
Rheumatic Fever	Diabetes	Frequent Colds (# per Year)_____
Other:	Other:	Other:

Has this student ever been around anyone known to have tuberculosis? ____ Yes ____No
Has he/she ever been skin tested for tuberculosis? ____ Yes ____No If yes, what year _____
Has he/she ever had a chest X-ray? ____ Yes ____ No
When did the student last visit the dentist? Date:_____ (recommended visit twice yearly)
Has the student had an eye examination? _____Yes ____ No Date: _____
By whom? _____

Comment on student's habits: How many hours sleep does he/she usually get? _____
Does student participate in outdoor activities? ____ Not at all ____ Moderately ___ Continuously

Does student prefer reading or watching Televison to outdoor activities? ____Yes ____No

Eating Habits: ____Only at mealtime ____ Occasionally between meals ____ Frequently between meals

List any other items helpful to the school program in planning for student's health:

Date:_____ Signature of Parent: _____