STUDENT MEDICAL RECORD FORM

Name _____ Sex _____ Date of Birth _____

Address _____

	Birthplace	Living?
Father/Legal Guardian		
Mother/Legal Guardian		

Children in household	Date of Birth	Children in household	Date of Birth
1.		4.	
2.		5.	
3.		6.	

Previous illnesses, operations, or allergies - please give age or date
1.
2.
3.
4.

IMMUNIZATIONS/EXEMPTIONS SEE REVERSE SIDE	1st	2nd	3rd	4th	5th
DPT, TD					
Polio					
MMR					
Hepatitis B					
Hib					
Tuberculin Test (Mantoux)					
Varivax					

PHYSICAL EXAMINATION

Eyes	Allergies	General Appearance
Vision Exam	Throat	Speech
Ears	Heart	Height
Audio Exam	Lungs	Weight
Skin	Orthopedic Posture	Hematocrit/HGB
Glands	Feet	Lead Screening
Nose	Abdomen	Blood Pressure HR

MEDICAL RECOMMENDATIONS

Date	Physician's Signature
Address	Phone Stamp