

STUDENT MEDICAL RECORD

Only designated staff, such as the school nurse or physician, will have access to the completed form.
This form will be stored in a locked file.

Name _____ Birth Date _____

Address _____

_____ Social Security Number _____

Name of Father _____ Name of Mother _____

History (Past illnesses and allergies. Please check those he/she has had.)

- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Measles

- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Ear Infections
- ☐ Other

- Allergies:
- ☐ Asthma
 - ☐ Hay Fever
 - ☐ Insect Bites
 - ☐ Penicillin
 - ☐ Other Drugs

Explain briefly factors as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience

Indicate physical problem by check: Hearing () Heart () Sight () Speech ()

Other _____
SPECIFY

IMMUNIZATIONS – An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Records considered official are:

State Immunization Record

Health Provider Record – must have signature, stamp, or initials next to each date.

Physician's Record

County Health Department Record

Official Immunization Record from another state

School Immunization Record

LABORATORY RECORD

TB SKIN TESTS	Type*	Dates Given	Given by	Date Read	Read by	Impression
	<input type="checkbox"/> PPD Mantoux	/ /		/ /		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/ /		/ /		<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD Mantoux	/ /		/ /		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/ /		/ /		<input type="checkbox"/> Neg
	<input type="checkbox"/> PPD Mantoux	/ /		/ /		<input type="checkbox"/> Pos
	<input type="checkbox"/> Other	/ /		/ /		<input type="checkbox"/> Neg

*If required by school entry, must be Mantoux unless exception granted by local health department

CHEST X-RAY Film date: ____/____/____ Impressing: ☐ Normal ☐ Abnormal

Person is free of communicable tuberculosis ☐ Yes ☐ No

Signature/Agency _____