NEW STUDENT MEDICAL RECORD FORM
(Grades 1 – 8)

Form must be returned by July 30th[t] to the school office

This section to be completed by Parent/Guardian:

Child's Name:______________________________________ ☐ Female ☐ Male Date of Birth: ___/___/___

Address:____ Grade: __________

City: __________________________ ST: _______ Zip:_________________

In case of emergency: Preferred Hospital: _____________________________

Dentist: _________________________ Phone #: (____) ______________

This section to be completed by a physician and/or other appropriate medical personnel:

Physical Examination Date: ________________ ☐ Normal ☐Abnormal

Weight ________________ Height _______________ Blood Pressure ________________

Is child able to participate in all regular physical and athletic activities? ☐ Yes ☐ No

Restrictions:____

Immunizations Dates

DTaP or
DPT ________ ________ ________ ________ ________ GR 7: Tdap/Td ________

POLIO________ ________ ________ ________

MMR _________ _________ HEPB ________ _________ _________ VARICELLA _________

HIB ________ ________ ________ ________

OTHER ____

TB Test: (Required for all students from outside the U.S. within 90 days) Date: ________ Type:________ Result:________

Allergies: ____

Medication: ____

Medical conditions/diseases: ____

____

Physician's Name: (Please print) _____________________________________ **Phone #** (____) ___________

Address: ____________________________ **City:** _________________ **State:** ______ **Zip:** ________

Physicians Signature: ________________________________ **Date:** ______________________