



NEW STUDENT MEDICAL RECORD FORM (Grades 1 – 8)

Form must be returned by July 29th 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:** _____