

**APIAL MEDICAL HISTORY REPORT
FOR RESPECTIVE SCHOOL NURSE'S OFFICE AND FOR ATHLETIC PARTICIPATION**

School Name _____.

NOTE TO PARENTS/GUARDIANS: Please fill in the information requested below for our health records. When you have completed this Medical History Report, please ask your family health care provider to complete the Health Report on the back of this page. Return the completed reports to the school **no later than the second week of the school year.** **A copy of an updated shot record is required for all incoming 7th graders.** All medical records are kept strictly confidential.

Student's Name _____ Birth date _____ Grade _____

Parent/Guardian's Name _____ Relationship _____

Parent/Guardian's Phone Numbers: Home _____ Cell _____ Work _____

Physician's Name _____ Phone _____

Dentist's Name _____ Phone _____

Insurance Plan _____ Phone _____

(Please attach proof of insurance)

Has the student ever had any of the following?

	Y	N		Y	N		Y	N
Asthma or lung disease			Seizures, fits or convulsions			Electroencephalogram (EEG)		
Allergies (list below)			Diabetes			Anemia		
Hearing difficulty in either ear			Spells of blurred vision or fuzzy vision or spots in front of eyes			Treatment for meningitis or bleeding		
Heart disease			Other vision difficulties			Wears contact lenses		
Behavior difficulty			Dental bridge or false teeth			Concussion or head injury		
Fainting spells			Pain in neck or stiff neck			Slipped disc or pinched nerve		
Defect of the spine or any other part of the body			Pain in shoulder blades			Tetanus toxoid & booster inoculation within the past ten years		
Rheumatic fever			Numbness or tingling of hands or feet			An illness lasting more than a week Date: _____		
Kidney trouble			Weakness or paralysis of hand or leg			Presently under a physician's care		
List recent surgeries			Injuries requiring medical attention Date: _____			List current medications		

Please list allergies and any further comments:

I have reviewed this medical history report and, to the best of my knowledge, it is accurate. In signing this form, I authorize the school administration to provide medically necessary information about my child to those persons who have a need-to-know.

Parent/Guardian Signature

Date

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School Name_____.

(To be completed by a health care provider)

Student's Name _____ Grade _____

To the Health Care Provider:

Please check "yes" or "no" to the questions below. If "yes" is checked, would you also specify your recommendations to the school in the space provided below. Also, please note vision test results.

	<u>NO</u>	<u>YES</u>
1. Is there any defect of vision, hearing, or speech for which the school could compensate by special seating or other action?	_____	_____
2. Is there any physical defect, including nutritional status, which would limit the student's participation in:		
Classroom activities?	_____	_____
Physical education?	_____	_____
Competitive athletics?	_____	_____
3. Is the student subject to conditions, which make for classroom emergencies, e.g., epilepsy, fainting, diabetes, or allergies?	_____	_____
4. Is there any mental, emotional, or physical condition of a privileged nature for which the student should remain under your periodic observation?	_____	_____
5. Does this student have any other medical problem with which the school should be concerned?	_____	_____

Additional comments:

Height _____ **Weight** _____ **Pulse** _____ **Blood Pressure** _____

	Normal	Abnormal	Remarks
Respiratory			
Cardiovascular			
Abdomen			
Hernia			
Musculoskeletal			
Neurological			
Deformities	****	****	
Surgical Scars	****	****	
Skin			
Genitalia			
Urinalysis (sugar)			

I certify that I have on this date reviewed the medical history and examined this individual and find that he/she is is not physically able to compete in supervised interscholastic athletics.

Examining Health Care Provider's Signature _____

Date of Examination _____

Address _____

Phone Number _____