Student Medical Record



This form to be completed by the student's physician and then kept on file at the school. It must be completed for all children who are a) enrolling at Miramonte school for the first time, and b) entering grade seven.

An official record of immunization must accompany this medical record for all students entering school for the first time in the United States, regardless of age. Acceptable records are: *A California State or other state official immunization record, *A School immunization record, *A Health Provider record from a physician or county health department - must include signatures or stamps next to each date as illustrated below.

Student Full Name:			Birth Date - mm/dd/yyyy:			
Street Address:			Social Security Number:			
City State, ZIP:			Father's Name:			
Grade:	□K □1 □2 □3 □4 □5 □6 □7 □8			Name:		
Medical Histor	у					
Illnesses:	Check all thos	se that apply		Allergies:		
☐ Cancer	☐Heart Disease		☐Whooping Cough	□Bees □Peanuts		
☐Chicken Pox	□Measles		☐Ear Infection	☐Other Insects ☐Penicillin		
□Diabetes	☐Rheumatic Fever		□Asthma	☐Other Allergies*		
□ Diphtheria		Scarlet Fever		*List Allergies		
□Epilepsy	<u> </u>	Tuberculosis		M/west-resolvers/secto		
Immunizations	Verify by sign	ature or stamp				
DPT Series			Polio Series			
	Date	Signature or stamp	an Times	Date	Signature or stamp	
DPT #1			Polio #1			
DPT #2	1 1	Solders of M. Anni (Shin S. McPallistin) of A. V. A. M. Allerson, and construct any control of the control of t	Polio #2	1 /	Through School paint (School School S	
DPT #3						
DPT Booster			Polio Booster			
DPT Booster		Andre Source community, Service LECT States and Service States in Service States of the Constitution of th				
DPT Booster					The first and a disconnect of the Popular to a company of the contract of the	
DTap Booster	Must be given after 7th birthday		Varicella			
	Date	Signature or stamp		Date	Signature or stamp	
Immunization			Immunization			
			or Had Chicken Pox			
MMR			Hepatitis B			
	Date	Signature or stamp		Date	Signature or stamp	
Immunization #1		Problem 61 VI. Are transaction or construction of "Management of National Problems of Nationa	Immunization #1	1 1		
Immunization #2		U-1	Immunization #2	i	May Found & Assessment sweeting below to the second	
			Immunization #3	j ī		
Mantoux TB Testing]					
Date Tested	Date Read	Read By		MM induration	Result	
				mim	☐Positive ☐Negative	
/	1			mm	□Positive □Negative	
If positive, a chest X-Ray				TO A STATE OF THE		
X-Ray Date	Impression	Free of TB?	Signature and Age	ency		
,	□Normal □Ab	normal Yes No				



Student Physical Exam

				Height			
Student Name:	MY Production of the Control of the		n Grand Arman Allaharan Alaman	Weight			
				Blood Pressure			
Area	Result		Comments				
Skin	□Normal □Abnormal	☐Not Tested					
Eyes, Vision, Glasses	□Normal □Abnormal	☐Not Tested					
Ears & Hearing	□Normal □Abnormal	☐Not Tested					
Nose & Throat	□Normal □Abnormal	☐Not Tested	40-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-				
Mouth & Teeth	□Normal □Abnormal	☐Not Tested	Control of the Contro				
Speech	□Normal □Abnormal	☐Not Tested					
Glands	□Normal □Abnormal	☐Not Tested	Brown St. Common and an array special and accommon and accommon and accommon and accommon and accommon and accommon accommon and accommon				
Chest & Lungs	□Normal □Abnormal	☐Not Tested					
Cardiovascular	□Normal □Abnormal	☐Not Tested					
Abdomen							
Enlargement	□Normal □Abnormal	☐Not Tested					
Tenderness	□Normal □Abnormal	☐Not Tested					
Hernia	□Normal □Abnormal	☐Not Tested					
Spine & Back	□Normal □Abnormal	☐Not Tested					
Posture	□Normal □Abnormal	☐Not Tested					
Extremities	□Normal □Abnormal	☐Not Tested					
Genitourinary	□Normal □Abnormal	□Not Tested					
Nervous system	□Normal □Abnormal	☐Not Tested					
Reflexes	□Normal □Abnormal	☐Not Tested					
Nutritional atatus and							
Nutritional status and g	eneral appearance						
Recommendations for	additional medical or	dental core					
r coommendations for a	additional medical of	dental care					
The student may partic □Yes □No	ipate in a normal phy	sical education prog	gram which includes a	ctivities such as running, jumping, and tumbling			
If student must be restricted from participating in activities such as those above, indicate activities that are permitted							
			Annual An				
Physician's Signature				Date/			
Business Address							