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 toxid & 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.

	NO	YES
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