



HEALTH RECORD FORM

TO BE COMPLETED BY PARENTS

Student's name \_\_\_\_\_

Family

First(given name)

Middle

Birth Date \_\_\_\_\_ (Day/Month/Year) Sex o M o F

Name of father \_\_\_\_\_ Occupation \_\_\_\_\_

Name of mother \_\_\_\_\_ Occupation \_\_\_\_\_

STUDENT HEALTH HISTORY:

Table with 6 columns: Category, yes, no, Category, yes, no. Rows include Neurological, Cardiac, Respiratory, Integumentary, Urological, Hospitalizations/Surgeries, and Other.

IMMUNIZATIONS:

Table with 2 columns: Immunization, Dates given. Rows include DPT\*, MMR\*, Polio\*, Varicella, Hepatitis A and B, BCG, Meningococcal, HPV, and Other.

\* M'KIS Admission requirement

Describe abnormalities/conditions above and dates involved:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List allergies (include food, medications, insect sting, environmental, etc)

\_\_\_\_\_

Describe reaction(s)

\_\_\_\_\_  
\_\_\_\_\_

Treatment for reaction(s)

\_\_\_\_\_

Medications the student is taking on a regular basis:

Name of medications \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_  
Purpose \_\_\_\_\_

Name of medications \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_  
Purpose \_\_\_\_\_

In the event of an emergency involving my child, I authorize MKIS to take whatever action is deemed necessary.

Parents name \_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_

(Please, go to the back of this form)

**TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER**

Student's name \_\_\_\_\_ Date \_\_\_\_\_  
*Family First(given name) Middle*

		Significant Findings /Comments
Height		
Weight		
Nutritional Status		
Eyes: Visual acuity Pupil, Convergence Color blindness	<b>Left</b> _____ <b>Right</b> _____	
Ears/ Hearing	<b>Left</b> _____ <b>Right</b> _____	
Nose		
Throat/ Lymph Nodes		
Lungs		
Heart	Sounds _____ Rhythm _____ Rate _____ Blood pressure _____	
Abdomen		
Uro/Genital		
Musculoskeletal	Spine _____ Feet _____ Scoliosis _____	
Neurological		
Blood group and Rh factor ( If known )	A B O AB Rh + -	

Tuberculin test (PPD): Date \_\_\_\_\_ Result: Neg. \_\_\_\_\_ Pos. \_\_\_\_\_ (mm swelling)

If PPD is positive, chest X-ray is required: Date \_\_\_\_\_ Result \_\_\_\_\_

The student is / is not able to fully participate in physical education classes/school activities.

Limitations \_\_\_\_\_

Follow-up recommended \_\_\_\_\_

Physician's name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

Telephone No. \_\_\_\_\_