S t. Mary's International School

HEALTH RECORD FORM

For all new students

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☞ **To be completed by a parent / guardian** * Please print or type

Student's Name	Last	First	
Grade		Date of Birth:	mm/dd/yyyy

Contact Information

Home Phone:		Home Address:	
Mother's Mobile:			
Mother's Work:			
Father's Mobile:			
Father's Work:			

Emergency Contact (Other than the parents)	Name:	Phone:	Relationship:

Medical/Physical Conditions

Does your son suffer from any of the following:

Asthma	Yes / No	Epilepsy	Yes / No
Joint / Back Pain	Yes / No	Nose Bleeding	Yes / No
Heart Condition	Yes / No	Diabetes	Yes / No
Frequent Headaches / Migraines	Yes / No	Skin Disease	Yes / No

List other medical / physical conditions or limitations and clarify any Yes answers from above:

List any surgeries (include date) that your son may have had:

Allergies (Food / Drug and Bee Allergies) List Reaction	Allergy:	Reaction:

Medications *List all prescription medications (name, dose, and frequency) that your son takes*

Permission to Dispense Non-Prescription Medications

Tylenol	Yes / No	Antacids (Tums / Pepto Bismol)	Yes / No
Motrin (Ibuprofen)	Yes / No	Cough Medicine / Decongestant	Yes / No

Immunizations

Immunization (Fill in year vaccine administered)	Early Childhood				4-6 yr Age	11-12 yr Age
Required						
Diphtheria / Tetanus (Tdap / DTap)						
Polio (IPV or OPV)						
Mumps / Measles (MMR)						
BCG (If no BCG then TB test)						
TB / PPD test (Within 3 years if no BCG)	Year	Result				
Recommended						
Hepatitis B (Only 3 doses if not given during infancy)						
Chicken Pox (Varicella)						
(If not immunized – print year had Chicken Pox)						

Parent / Guardian Signature: **Date:**

PHYSICAL EXAMINATION

Required for all students accepted to St. Mary's International School

☞ **Must be completed by a physician**

Student's Name: Last First | Age:

Date of Evaluation (must be within 6 months start of school year or admission): (mm/dd/yyyy)

Health Assessment

Height: cm	B / P	/
Weight: kg	Pulse:	
BMI:		

☐ Age appropriate history completed

List any previous surgeries:

Physical Examination

	1. Within Normal		2. Abnormal findings	
HEENT	1 / 2	Neurological	1 / 2	
Lungs	1 / 2	Gastro Intest.	1 / 2	
Heart	1 / 2	Extremities	1 / 2	
Skin	1 / 2	Genital	1 / 2	
Urinary	1 / 2	Scoliosis	1 / 2	

Significant physical findings, comments, and recommendations for medical monitoring:

Screenings

Vision	
Screening with corrective lenses	☐
Pass	☐
Referral made	☐
Dental	
Pass	☐
Referral made	☐
Auditory	
Pass	☐
Referral made	☐

Developmental

	Normal	Concern Identified
Emotional / Social		
Problem Solving		
Language / Communication		
Fine Motor Skills		
Gross Motor Skills		
Speech		

State / Clarify any concerns:

Medical Concerns

☐ Well child / No identified concerns to school programs or activities.

List any medical conditions identified that are important to school / physical activity (i.e. asthma, diabetes, seizure disorder, allergies, bone/joint diseases):

List any restricted activities or special needs:

List any medications student is currently prescribed (include dosage and frequency):

Physician Signature: **Date:**

Physician / Clinic address / Phone number (*please print or stamp)

Name: Phone Number:

Address: