Medical Evaluation Record of Student
(With Physician's Recommendations)

The following information is requested so that the school and parent can work together to meet the physical, intellectual, and emotional needs of the child.
(to be filled in by the physician)

Student's name: ______________________ Birthday: ____________ Biological Birth Gender ☐ Male ☐ Female

Address: ______________________ Father's name: ______________________

______________________ Mother's name: ______________________

School: ______________________

Question	No	Yes	If yes, explain
I. A. Is student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma or other?	☐	☐	
B. Does student have other medical problem with which the school should be concerned?	☐	☐	
C. Is there evident need for dental care?	☐	☐	
D. Is there a hearing defect for which the school could help compensate by seating or other action?	☐	☐	
E1. Has the student had a vision screening test?	☐	☐	Date: Result:
E2. Are there ocular defects that indicate a need for referral to an eye doctor?	☐	☐	
E3. Are there any visual defects for which the school could help compensate by seating or some other action?	☐	☐	

II. Immunization is required by law. It is expected that the physician will administer whatever inoculations are indicated at the time of this examination and record these and other previous inoculations.

Please attach a copy of the immunization record for our files.

III. Have there been any illnesses, accidents, operations, or congenital defects that limit the student's participation in:

Classroom activities? ☐Yes ☐ No Physical education activities? ☐Yes ☐ No Swimming? ☐Yes ☐ No

If so, explain: ______________________

IV. Is there any mental, emotional, or physical condition, for which the student should remain under your periodic observation?

☐Yes ☐ No If Yes, explain: ______________________

____

At what interval does the student need rechecks? ______________________

V. Physician's recommendation to school: ______________________

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I would like the ☐ **nurse** ☐ **teacher** to contact me regarding this student ______________________

Date of examination: ____________ Signature: ______________________

Office Address: ______________________ Telephone: ______________________

Street City State Zip

C-30:73 Prepared by the General Conference Department of Health and Education

Health Inventory

(to be filled in by parent, before examination by physician)

1. Name of Student: ______________________ Age: _________ Birthdate: _________________
Address: __________________________ Telephone: ___________________________
Father's name: __________________________ Mother's name: ___________________________

Whom to notify in case of illness (give addresses and phone numbers)
____ ____
____ ____
Does student live at home with parent? □ Mother □ Father □ Other _________________
Does student have coverage by accident or hospitalization policy? (state type) _____________________________

2. Past illnesses (please check those that student has had)

□ Measles
□ Whooping cough
□ Polio
□ Rheumatic fever
□ Scarlet fever
□ Diphtheria
□ Chickenpox
□ Diabetes
□ Heart disease
□ Chorea (St. Vitus' Dance)
□ Epilepsy
□ Frequent colds (Number per year)
□ Hay fever or asthma

List any other serious illnesses, operations, or injuries, and age when occurred.

3. Has this student ever been around anyone known to have tuberculosis? □Yes □ No
Have they ever been skin tested for tuberculosis? Year ____________ □Yes □ No
Have they ever had a chest X-ray? Year ____________ □Yes □ No

4. When did the child last visit the dentist? (Recommend visit twice yearly) Date: _______________

5. Has the student had their eyes examined? Date: _______________
By whom? ___________________________

6. Comment on student's habits:
How many hours of sleep do they usually get each night? __________________
Do they participate in outdoor sports? □ Not at all □ Moderately □ Continuously
Do they prefer reading or watching TV to the above? □Yes □ No
Eating habits: □ Eats only at mealtimes □ In between meals occasionally □ Frequently

7. List any other items helpful to the school program in planning for student's health:

Date: _______________ Signature of Parent: ____