



MEDICAL PROFILE

Student Name: _____ Date of Birth: _____

In case of emergency, notify: Phone Name: _____ No: _____ Name: _____ Phone No: _____
Relation to student _____ Relation to student _____

IN CASE OF MEDICAL EMERGENCY, I understand a reasonable effort will be made to contact parents or guardian of the student. In the event I cannot be reached, I hereby give permission to the physician selected by the school to hospitalize, secure proper treatment for, and to order injection, anesthesia for my child named above.

Signature: _____ Home Phone: _____
Date: _____ Work Phone: _____

Immunizations: Record shot dates - or attach copy of Physician's Immunization Record

SHOT	#1	#2	#3	#4	#5
DTP					
HEP A					
HEP B					
HIB					
MMR					
POLIO					
VARICELLA					

TO WHOM IT MAY CONCERN:

_____ was examined on _____ and is physically able to participate in school activities. Restrictions and recommendations (if any): _____

*Signed: _____ M.D. Date: _____

Printed Name: _____

Address: _____

Phone: _____

NO STUDENT WILL BE ENROLLED WITHOUT A COMPLETED HEALTH CERTIFICATE

* Reverse side must be completed by Physician



Code: ✓ Negative
✗ Not Satisfactory (Explain)

Height: _____ Weight: _____

BP Temperature: _____

Skin: _____

Athlete's Foot: _____

Impetigo: _____

Infection: _____

Fungus: _____

Pediculosis: _____

Scabies: _____

Eyes: _____

Glasses ? _____

Ears: _____

Frequent Infection? _____

Tubes in now? _____

Nose: _____

Nosebleeds? _____

Sinusitus? _____

Throat _____

Tonsils? _____

Teeth: _____

Frequent toothaches? _____

Indicate (YES) if student is subject to:

Easy/Prolonged Bleeding _____

Fainting _____

Stomach Upsets _____

Constipation _____

NOTE: If any condition is remarkable, please describe severity and/or frequency of incidence, preferred treatment and whether or not controlled by medication.

Heart: _____

Murmur: _____

Rheumatic Fever: _____

Lungs: _____

Asthma: _____

Tuberculosis: _____

Abdomen: _____

Urine: _____

Genitalia: _____

Menstruation Begun: _____

Cramps: _____

Diabetes: _____

Hypoglycemia: _____

Neurological: _____

Seizures: _____

Frequent Headaches? _____

Further Comments (if any): _____

Disease, Surgery, Injuries: _____

Allergies - IMPORTANT - Describe most current reaction, the date occurred and the treatment received:

Bee/Wasp/Insect stings: _____

Chiggers/Mosquitoes: _____

Spiders/Ants/Other: _____

Poison Ivy, Oak, Sumac: _____

Foods: _____

Drugs - (Antihistamines - Antitoxin - Aspirin - Penicillin Other): _____

PLEASE NOTIFY SCHOOL IF ANY MEDICATIONS NEED TO BE TAKEN DURING THE SCHOOL DAY. THOSE WILL NEED TO BE KEPT LOCKED IN THE SCHOOL OFFICE. NO MEDICATION WILL BE ACCEPTED WITHOUT A PHARMACY OR MANUFACTURER'S LABEL.

CURRENT MEDICATIONS - Medicines taken routinely:

