



## MEDICAL FORM

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. Please fill out the information requested in Section A. Section B is to be completed by a physician or a health care provider. Section B1 may be certified by the transcription of information from the certificate of immunization

### SCHOOL HEALTH APPRAISAL

#### Personal details

Child's Name: \_\_\_\_\_  
*First*
*Family*

Child's date of birth: \_\_\_\_\_ Place: \_\_\_\_\_

Home Address: \_\_\_\_\_  
 \_\_\_\_\_

Mother's Name: \_\_\_\_\_ phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ phone: \_\_\_\_\_

Contact person in case of emergency (please indicate name and phone number):  
 \_\_\_\_\_ phone: \_\_\_\_\_

#### SECTION A – HEALTH HISTORY

Does your child have any of the problems listed below?

	YES	NO
1. Allergies or reactions: ( for example: food, medication, animals or other)		
2. Hay fever, asthma or wheezing		
3. Eczema or frequent skin rashes		
4. Convulsions / Seizures		
5. Heart trouble		
6. Diabetes		
7. Frequent colds, sore throats, earaches ( 4 or more per year)		
8. Trouble with passing urine or bowel movements		
9. Shortness of breath		
10. Speech problems		
11. Dental problems : date of last examination		
12. Other		



If you responded “yes” to any of the above, please make specific comments as to approximate dates of illnesses and specify any other chronic or recurring illnesses not on the list:

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Does your child take any medication regularly?  Yes  No

If yes, what medication? \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Please mention any specific activities to be restricted (and reason) or any conditions that could affect your child’s learning or activities in school:

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Do you suspect that your child has learning difficulties?  Yes  No

If yes, what are the symptoms?

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Is your child diagnosed with special education needs?  Yes  No

If yes, please indicate the diagnoses and the treatment:

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## SECTION B – 1. IMMUNIZATIONS

VACCINE	DATE ADMINISTRATED			
	Type	day / mo / year	Type	day / mo / year
DTaP / DTP / TD ( specify type)		1.		6.
		2.		7.
		3.		8.
		4.		9.
		5.		10.
Haemophilus influenzae type B (HIB)		1.		3.
		2.		4.
POLIO IPV / OPV (specify type)		1.		4.
		2.		5.
		3.		
MMR	1.		2.	
Varicella ( Chickenpox)	1.		2.	
Hepatitis B HBV	1.		3.	
	2.			
Pneumococcal Conjugate (PCV)	1.		3.	
	2.		4.	
Other Vaccines				
Indicate physician diagnosis or laboratory evidence of immunity as applicable				
Vaccines waived due to reactions/contraindications / religious objections				

2. Medical Examination: to be completed in full by a physician. It must be performed within six months of arrival at school. An examination for some other purpose within this period is acceptable. The examination is for determining fitness to engage in school activities.

Hgt ..... Wt ..... B.P. .... Hgb ..... Urine .....

Vision ..... Eyes ..... Ears ..... Nose ..... Throat .....

Teeth ..... Heart ..... Lungs ..... Abdomen .....



Extremities ..... Spine .....Mental status .....

Glasses (reading, distance, all times): .....Hearing aid: .....

Braces (specify): ..... Other corrective devices (specify):.....

Regular medications (specify): .....

Skin (rashes, scars): .....

Physical restrictions: .....

General appraisal: .....

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### RECOMMENDATIONS

Is there any defect of vision, hearing or other condition for which the school could help by seating or other action?  Yes  No

If yes, please explain:

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

Should the student's activity be restricted because of any physical defect or illness?  Yes  No  
If yes, check below and explain degree of restriction:

Classroom  Playground  PE lessons  Swimming pool  Other

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

I have examined the person herein described and have reviewed the health history on this form. It is my opinion that this person is physically able to engage in all school activities, except as noted above.

Physician's Name: \_\_\_\_\_

Stamp and signature: \_\_\_\_\_

Date: \_\_\_\_\_