ST. JOHN'S SCHOOL

STUDENT INFORMATION

SCHOOL YEAR 2018-2019

Information requested on this form will help the school provide the appropriate care for your child during school hours. Please fill out completely. **One (1) form per child. This form is required for all students for each year the student attends St. John's School.**

Student Name: ____
Last *First* *M.I* *Nickname*

Grade: ____________ Gender: (√) ( ) Male ( ) Female Date of Birth: ______________________

Parent/Guardian Contact Numbers: ______________________________
Cell *Home* *Work*

Email Address: ____

Ethnic Background (Optional): ________________ Religious Affiliation(Optional): ________________

STUDENT RELEASE INFORMATION

I hereby give permission for St. John's School to release my child to the following individuals. I understand that I must notify school of any subsequent changes.

Name: ______________________________ Relationship: ______________
Last *First* *M.I*
Phone Numbers: ______________________________
Cell *Home* *Work*

Name: ______________________________ Relationship: ______________
Last *First* *M.I*
Phone Numbers: ______________________________
Cell *Home* *Work*

EMERGENCY CONTACT INFORMATION (Other than parents)

Name: ______________________ Phone Numbers: ______________
Last *First* *Cell* *Work*

Name: ______________________ Phone Numbers: ______________
Last *First* *Cell* *Work*

MEDICAL INFORMATION

Health Plan: ______________ Insurance Number: ______________ Clinic: ______________

STUDENT MEDICAL HISTORY INFORMATION *(Please indicate if your child has/had the following:)*

ILLNESS	YES/NO	ILLNESS	YES/NO	ILLNESS	YES/NO	ALLERGIES (LIST)
Anemia		Diabetes		Mumps		
Asthma		German Measles		Rheumatic Fever		
Chickenpox		Heart Disease		Tuberculosis		
Convulsion/Seizures		Measles		Other (Specify)		

Has your child ever been under the care of a Psychologist, Psychiatrist or other mental health treatment provider? ___Yes ___No
Other significant illness, accidents, surgery, limitations, disabilities and medications the school should be aware of: ______________

____

Parent/Guardian Signature:______________________________ Date: ______________

SCHOOL YEAR 2018-2019

PHYSICAL EXAMINATION *(To be completed by a Physician)*

Height:________________ Weight: ______________ BP: ____________ T-P-R _____/_____/_____

Vision (R) __________ Vision (L) __________ Hearing (R)__________ Hearing (L) __________

Description	Normal	Abnormal	Examined	Comments
General Appearance	_____	_____	_____	_____
Skin, Hair, Nails	_____	_____	_____	_____
Optic Fundus	_____	_____	_____	_____
Ears: External	_____	_____	_____	_____
Auditory Acuity	_____	_____	_____	_____
Tympanic Membrane	_____	_____	_____	_____
Nose, Mouth, Throat	_____	_____	_____	_____
Speech	_____	_____	_____	_____
Teeth, Gums	_____	_____	_____	_____
Neck (Glands, Thyroid)	_____	_____	_____	_____
Cardiovascular	_____	_____	_____	_____
Respiratory	_____	_____	_____	_____
Gastrointestinal	_____	_____	_____	_____
Genito-Urinary	_____	_____	_____	_____
Musculo-Skeletal	_____	_____	_____	_____
Scoliosis Screening	_____	_____	_____	_____
Neurological	_____	_____	_____	_____
Nutritional Status	_____	_____	_____	_____
Behavior during exam	_____	_____	_____	_____
Other	_____	_____	_____	_____

STUDENT LIMITATIONS: Is this student subject to any condition that limits participation in:

	Yes	No	Comments
1. Classroom activities?	_____	_____	_____
2. Physical Education?	_____	_____	_____
3. Interscholastic Sports?	_____	_____	_____

Is this child on medication?__________ Medication (please list):____________________

Significant Family History (Physical health, social, economical) ____________________

ANNUAL PPD SKIN TEST AND IMMUNIZATIONS:

1. PPD skin test results: (It is the school's policy that each child obtain a PPD skin test on an annual basis.) If PPD results are positive, a copy of chest X-ray and physician's report must attach.

Date administered: ________________ Date read: ____________ Results: _____ Negative _____ Positive

2. Are immunizations current per the Public Health Schedule and requirements for school enrollment? _____Yes _____ No

3. Please attach a copy of student's immunization record.

Physician Signature:______________________________ Date: ______________

Print Name: ______________ Phone Number: ____________ Clinic: ______________