ST. JOHN'S SCHOOL

STUDENT MEDICAL INFORMATION

SCHOOL YEAR 2023-2024

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): _____

Village of residence: _____

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: _____

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SCHOOL YEAR 2023-2024

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: _____