

SCHOOL YEAR 2024-2025

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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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 be attached.

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: _____