ST. JOHN'S SCHOOL

# STUDENT MEDICAL INFORMATION

## SCHOOL YEAR 2025-2026

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 and updated as information changes.**

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: _____

ST. JOHN'S SCHOOL

# STUDENT MEDICAL INFORMATION

## SCHOOL YEAR 2025-2026

**All incoming St. John's School students will require an updated physical examination, and tuberculosis (TB) skin test.**

### 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) _____

### PPD SKIN TEST AND IMMUNIZATIONS:

1. PPD skin test results: If PPD results are positive, a copy of the chest x-ray, and a TB evaluation clearance form 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: _____