

### STUDENT MEDICAL RECORD

This form is to be completed by the student's parents and returned to Chapin **by August 1.**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_

Street Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian Name(s) \_\_\_\_\_

Father's Daytime Phone \_\_\_\_\_ Mother's Daytime Phone \_\_\_\_\_

Father's Cell Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

*In the case of an emergency, the school will call the nearest ambulance service and will make every effort to contact the parent/guardian immediately.*

I give permission for my child to receive first aid.

Check one  
 YES  NO

I give permission for my child to receive Tylenol, Advil, or Motrin as a pain reliever/fever reducer, if necessary. **Please enclose doctor order form.**

YES  NO

If the School nurse is not available or if your child is on a class trip, do you give permission for another faculty member to administer the required medication?

YES  NO

**Past Illness:** Give age if child has had any of the following:

- Lyme Disease \_\_\_\_\_
- Asthma/Medication \_\_\_\_\_
- Learning Disabilities \_\_\_\_\_
- Scarlet Fever \_\_\_\_\_
- Seasonal Allergies/Medication \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Strep Infections \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Mononucleosis \_\_\_\_\_
- Eye Trouble \_\_\_\_\_
- Convulsive Disorders \_\_\_\_\_
- Allergies: Please specify insect, food, drug, etc. \_\_\_\_\_
- Bleeding Disorder \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_
- Operations \_\_\_\_\_
- Chicken Pox \_\_\_\_\_
- Other \_\_\_\_\_
- Ear Infections \_\_\_\_\_
- Epi-Pen \_\_\_\_\_

--Life threatening conditions will be shared with necessary staff.--

#### INFORMATION REQUIRED BY THE STATE FOR IMMUNIZATION PURPOSES:

**New Students:** Birth Country: \_\_\_\_\_ American school for first time? Yes \_\_\_ No \_\_\_  
 I have transferred from another state: Yes \_\_\_ No \_\_\_ Name of state \_\_\_\_\_  
 I have transferred from another country: Yes \_\_\_ No \_\_\_ Name of country \_\_\_\_\_

If your child is presently receiving care for any physical condition or takes medication on a regular basis, please note:

\_\_\_\_\_  
Please feel free to contact the school nurse if you have questions to discuss or information to share.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return this form to the Front Office by August 1. Thank you.



School Year \_\_\_\_\_

**STUDENT PHYSICAL TO BE COMPLETED BY PHYSICIAN**

This form is to be completed by a physician and returned to Chapin **by August 1**. Chapin School requires an examination every two years. However, **if a child plays competitive sports at Chapin, an annual physical is required.**

Student's Name \_\_\_\_\_ Examination Date \_\_\_\_\_

Current Medical Problems \_\_\_\_\_

Significant Past Medical History \_\_\_\_\_

\_\_\_\_\_

Surgeries \_\_\_\_\_

Medications \_\_\_\_\_

Allergies \_\_\_\_\_

Height \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. B/P \_\_\_\_\_ Pulse \_\_\_\_\_

Glasses/Contacts \_\_\_\_ Yes \_\_\_\_ No Vision \_\_\_\_ OD \_\_\_\_ OS Hearing \_\_\_\_ Pass \_\_\_\_ Fail

*N = Normal ABN = Abnormal*

General	N	ABN	Heart	N	ABN	Neurologic	N	ABN
Eyes	N	ABN	Lungs	N	ABN	Musculoskeletal	N	ABN
Ears	N	ABN	Abdomen	N	ABN	Scoliosis	N	ABN
Throat	N	ABN	Genitalia	N	ABN	U/A		
Teeth	N	ABN	Hernia	N	ABN	_____		
Neck	N	ABN	Skin	N	ABN	_____		

Tanner Stage \_\_ I \_\_ II \_\_ III \_\_ IV \_\_ V

Abnormal Findings \_\_\_\_\_

\_\_\_\_\_

Approved for competitive sports with the following restrictions:

Recommendations \_\_\_\_\_

\_\_\_\_\_

**Attach all current Immunization Records including dates.**

Physician's Signature \_\_\_\_\_ Stamp \_\_\_\_\_

Date \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Please return this form to the Front Office by August 1. Thank you.