Student Full Name: _____Date of Birth:_____

Student Medical Form

This form is to be completed for new students upon admission, and returning students prior to starting grades 3 and 6. Secondary students must complete the medical exam every two years in order to participate in after school activities or athletics. The first portion of the form is to be completed by parents, and the second portion of the form is to be completed by a physician.

To be completed by parents:

Emergency Medical Evacuation Insurance:

Does your child have International SOS or other emergency medical evacuation coverage?

- ☐ No
- ☐ Yes---- Please complete:

Name of company: _____

Contact #: _____Policy #: _____

Medications:

Attention: If you want your child to take medication at school, you must send a note with the medication with the name of the medication, dose (how much), time to take the medication, and for how many days.

1. The nurse's office has the following medications. Please check the box next to the medication which gives the school nurse permission to give it to your child if needed.
   - ☐ Throat Lozenges- for sore throat relief
   - ☐ Acetaminophen/Paracetamol (Tylenol)- for headaches, fever and cramps
   - ☐ Ibuprophen (Motrin)- for headaches, fever and cramps
   - ☐ Diphenhydramine (Benadryl)- for allergic reactions
   - ☐ Topical ointments and lotions- for grazes, cuts and rashes
   - ☐ Tums (Antacid/ Calcium supplement)- for stomach aches
2. Does your child take any medications, vitamins, minerals, or supplements on a regular basis?
   - ☐ No
   - ☐ Yes----- Please list name of medication, dose, and reason for medication:
     - _____
     - _____
     - _____

Allergies:

1. Is your child allergic to any medication, food, or environmental factor?
   - ☐ No
   - ☐ Yes----- Please list allergies and reactions:
     - _____
     - _____

Student Full Name: _____Date of Birth:_____

- _____

Health Conditions

Does your child have a history of any of the following conditions?

- ☐ Concussion
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Seasonal Respiratory Allergies
- ☐ Diabetes
- ☐ Seizures (Epilepsy)
- ☐ Heart Problems
- ☐ Serious injuries
- ☐ Eye Problems
- ☐ Bone or Joint Problems
- ☐ Serious Accidents
- ☐ Chronic cough
- ☐ Glasses or Contacts (circle which one/s)
- ☐ Skin Problems
- ☐ Cancer
- ☐ ADHD /ADD
- ☐ Frequent Headaches
- ☐ Severe Menstrual Cramps
- ☐ Chicken Pox
- ☐ Hearing Problems
- ☐ Teeth or Mouth Issues
- ☐ Anxiety/ Depression/ Bipolar (circle which one/s)
- ☐ Chronic Diseases
- ☐ Fever of more than 2 weeks
- ☐ Unexplained weight loss
- ☐ Frequent Stomach aches
- ☐ Anemia
- ☐ Bladder or Kidney Problems
- ☐ Blood or clotting disorders
- ☐ Hepatitis
- ☐ Frequent Nose Bleeds
- ☐ Other
- ☐ None of the Above

Please explain any checked boxes and give any additional information that would help the teachers or school nurse in the care of your child during the school day:

_____

_____

_____

_____

_____

PARENT SIGNATURE: _____ Date: _____

Student Full Name: _____Date of Birth:_____

To be completed by a medical physician:

Height (cm) :_____ B/P: _____/_____
Weight (kg): _____ Pulse: _____

Surgical History:

Has the child undergone any surgical procedure?

- ☐ No
- ☐ Yes----- Please specify when and the nature of surgery: _____
  _____

Physical Exam:

	Normal	Abnormal	Physician's Comments, Findings,Tests,ETC.
General Appearance			
Neurologic			
Musculoskeletal			
Skin, Scalp			
Eyes			
Vision Screening			
Ear, Nose, Throat			
Hearing Screening			
Speech			
Mouth, Teeth			
Glands, Thyroid			
Heart			
Lungs			
Abdomen			
Genitourinary			
Mental Health and Cognition			
Emotional Health +Behavioral Health			

Student Full Name: _____Date of Birth:_____

Vaccinations:

The below vaccinations are REQUIRED for WYIS school attendance. Please write the DATES the child has received the below vaccinations. Please attach a copy of the child's vaccination record. Note: Some vaccinations are given in combination <Example: Measles, Mumps, Rubella (MMR)>.

Required Vaccinations	**Date (mm/dd/yy)**				
Type	**1st**	**2nd**	**3rd**	**4th**	**5th**
Polio: 3-4 doses with at least one dose of Inactivated Polio Vaccine (IPV) required before start of school					
Diphtheria, Tetanus, Pertussis (DTP): 3 primary doses required before start of school; booster dose required age 1-6; booster of Td age 12-15.					
Measles: 1 dose required before start of school; 2nd dose required by age 6					
Mumps: 1 dose required before start of school; 2nd dose required by age 6					
Rubella: 1 dose required before start of school					
Hepatitis B: 3 doses required by start of school					

This student has <u>completed</u> the minimal immunization requirements for attendance at WYIS.

☐ Yes ☐ No

Physical Activities

(Normal physical education classes, swimming and competitive sports)

- ☐ Unrestricted
- ☐ Modified --- Please explain: _____
  _____

Communicable Disease:

In my opinion this student is free of any communicable disease.

☐ Yes ☐ No

Student Full Name: _____Date of Birth:_____

Tuberculosis Assessment:

All students attending WYIS must have a negative PPD or chest x-ray within the last 6 months, unless they have had a BCG vaccination within the last 5 years.

1. BCG vaccination received?
   - ☐ No ☐ Yes--- Date receive:_____
2. Last PPD date and result:_____
3. Last chest x-ray date and result:_____

This patient has had a negative PPD or chest x-ray within the past 6 months.

- ☐ Yes
- ☐ No---- Please indicate reason:
  - PPD/ Chest x-ray assessment was deferred due to BCG within past 5 years.
  - Other: _____

In my assessment, this patient is free of any signs or symptoms of tuberculosis.

- ☐ Yes
- ☐ No--- Please explain: _____
  _____

Additional Comments: _____
_____
_____

Doctor's Name (Block Letters): _____
Signature: _____ Date of Examination: _____

Office Stamp: