

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:
 - _____
 - _____

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○ _____

Health Conditions

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

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

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: _____

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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			

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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)				
	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 completed 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

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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: