



# La Sierra Academy

## Student Medical Record

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ CA Zip \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Name of Mother: \_\_\_\_\_

History (Past illnesses and allergies. Please check those he/she has had).

- |  |  |            |                                       |
|--|--|------------|---------------------------------------|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Rheumatic Fever | Allergies: |                                       |
| <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Scarlet Fever   |            | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Tuberculosis    |            | <input type="checkbox"/> Hay Fever    |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> Whooping Cough  |            | <input type="checkbox"/> Insect Bites |
| <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Ear Infection   |            | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other           |            | <input type="checkbox"/> Other Drugs  |
| <input type="checkbox"/> Measles       |  |            |                                       |

Briefly explain any factors, such as surgeries, serious accidents or injuries, congenital defects, speech defects, vision problems, which may affect the child's school experience.

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**IMMUNIZATIONS:** An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Official Records are:

- California State Immunization Record** (yellow Card)
- Health Provider Record** (must have signature, stamp, or initials next to each date)
- Physicians Record**
- County Health Department Records**
- Official Immunization Record from another state**
- California School Immunization Record** (CSIR or "blue card")

**\*LABORATORY RECORD**

TUBERCULOSIS ASSESSMENT			
<b>TB SKIN TEST</b> List most recent Test and result	Date Given  / /	Mm Indur  mm	Impression  ___ pos ___ neg
<b>CHEST X-RAY</b> (Required if skin Test is positive)	Film date: ___/___/___		
	Impression:    normal    abnormal		

\*To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at grade seven (this should include the scoliosis examination), c) at least once in grades nine through twelve, and d) at other grades when required by the Conference Board.

**For all new students and all students entering 9<sup>th</sup> Grade.**

**OVER PLEASE - Both Sides must be completed by your physician.**

# Physicians Examination\*

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Blood Pressure:** \_\_\_\_\_

**N: Normal    Ab: Abnormal    NE: Not Examined**

	<i><b>N</b></i>	<i><b>AB</b></i>	<i><b>NE</b></i>	<i><b>Explain Abnormalities</b></i>
Skin				
Eyes, vision, glasses				
Nose and Throat				
Ears, hearing				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen, enlargement				
tenderness				
hernia				
Spine, back				
Scoliosis for Grade 7				
Posture				
Extremities				
Genitourinary				
Nervous System, reflexes				

Nutritional status and general appearance of the child:

\_\_\_\_\_

\_\_\_\_\_

This student may participate in a normal physical education program which includes such activities as running, jumping, and tumbling.  Yes  No

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

\_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

Physician's Signature

Address: \_\_\_\_\_