STUDENT HEALTH FORM – KINDERGARTEN THROUGH FIFTH GRADE
REQUIRED FOR ATTENDANCE 2014-2015

STANLEY BRITISH PRIMARY SCHOOL

TO BE FILLED OUT BY PARENT OR GUARDIAN

CHILD'S NAME _____ GRADE _____

HOME ADDRESS _____ ZIP _____ HOME PHONE _____

ALLERGIES _____

MEDICATIONS _____

MEDICATION ROUTINE _____

NOTE: ANY MEDICATION TO BE DISPENSED DURING SCHOOL HOURS AND ACTIVITIES MUST BE ACCOMPANIED BY A MEDICATION PERMISSION FORM SIGNED BY A HEALTH CARE PROVIDER.

SURGERIES OR HOSPITALIZATIONS _____

ACCIDENTS _____

CONSENT TO TREAT

In the event of a medical emergency, I give Stanley British Primary School staff full permission and authority to secure whatever medical treatment is necessary for my child, in their judgment, and request notification of such medical emergency as soon as it practical. _____

PARENT SIGNATURE DATE

TO BE FILLED OUT BY HEALTH CARE PROVIDER

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____ GENDER _____

DATE OF EXAMINATION _____

HEIGHT _____ BLOOD PRESSURE _____

WEIGHT _____

EXAMINATION:

- ☐ EYES RIGHT: LEFT: CORRECTED: Y / N
- ☐ EARS _____
- ☐ NOSE _____
- ☐ THROAT _____
- ☐ HEART _____
- ☐ LUNGS _____
- ☐ ABDOMEN _____
- ☐ NEUROLOGIC _____

IMMUNIZATION RECORD: *In order for your child to attend school, immunization documentation must be on file at the school by the first day of attendance.*

NOTE to Health Care Provider: Please provide the family with a completed Immunization Record.

☐ Yes, Immunization Record is attached.

-PLEASE TURN OVER FOR REST OF FORM-

For School Use Only
DATE RECEIVED_____

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CHILD'S NAME _____ GRADE _____

DOES THE CHILD HAVE A PAST OR PRESENT MEDICAL HISTORY OF THE FOLLOWING (CHECK AND EXPLAIN WHERE NEEDED):

☐ ALLERGIES _____	☐ HEART _____
☐ ASTHMA _____	☐ SEIZURES OR FAINTING _____
☐ ATTENTION DEFICIT DISORDER _____	☐ SKIN CONDITIONS _____
☐ BEHAVIORAL _____	☐ SPEECH _____
☐ BOWEL/BLADDER _____	☐ SPINAL INJURY _____
☐ DIABETES _____	☐ TUBERCULOSIS _____
☐ HEAD INJURY _____	☐ VARICELLA (CHICKEN POX) _____
☐ HEARING _____	☐ VISION _____
☐ HEADACHES _____	☐ OTHER _____

CHRONIC ILLNESSES _____

COMMENTS OR RECOMMENDATIONS TO SCHOOL PERSONNEL: _____

_____

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE

PROVIDER NAME: _____ DATE: _____

SIGNATURE: _____ TELEPHONE: _____

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