

**STUDENT HEALTH FORM – MIDDLE SCHOOL STUDENTS  
REQUIRED FOR ATTENDANCE 2014-2015**

**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 \_\_\_\_\_

**SPORTS:**

I give my consent for my child to participate in Sports: \_\_\_\_\_  
PARENT SIGNATURE

**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:**

<input type="checkbox"/> EYES RIGHT: _____	<input type="checkbox"/> HEART _____
<input type="checkbox"/> EARS _____	<input type="checkbox"/> LUNGS _____
<input type="checkbox"/> NOSE _____	<input type="checkbox"/> ABDOMEN _____
<input type="checkbox"/> THROAT _____	<input type="checkbox"/> NEUROLOGIC _____

**-PLEASE TURN OVER FOR REST OF FORM-**

For School Use Only  
DATE RECEIVED \_\_\_\_\_

# STUDENT HEALTH FORM – MIDDLE SCHOOL STUDENTS

CHILD'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_

**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.

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

ALLERGIES _____	<input type="checkbox"/> HEART _____
<input type="checkbox"/> ASTHMA _____	<input type="checkbox"/> SEIZURES OR FAINTING _____
<input type="checkbox"/> ATTENTION DEFICIT DISORDER _____	<input type="checkbox"/> SKIN CONDITIONS _____
<input type="checkbox"/> BEHAVIORAL _____	<input type="checkbox"/> SPEECH _____
<input type="checkbox"/> BOWEL/BLADDER _____	<input type="checkbox"/> SPINAL INJURY _____
<input type="checkbox"/> DIABETES _____	<input type="checkbox"/> TUBERCULOSIS _____
<input type="checkbox"/> HEAD INJURY _____	<input type="checkbox"/> VARICELLA (CHICKEN POX) _____
<input type="checkbox"/> HEARING _____	<input type="checkbox"/> VISION _____
<input type="checkbox"/> HEADACHES _____	<input type="checkbox"/> OTHER _____

CHRONIC ILLNESSES \_\_\_\_\_

COMMENTS OR RECOMMENDATIONS TO SCHOOL PERSONNEL: \_\_\_\_\_

**SPORTS:**

- Cleared for all sports without restriction
  - Cleared for all sports with the following recommendations: \_\_\_\_\_
  - Not cleared
    - Pending further evaluation: \_\_\_\_\_
    - For any sports: \_\_\_\_\_
    - For certain sports: \_\_\_\_\_
- Reason: \_\_\_\_\_

**HEALTH CARE PROVIDER INFORMATION AND SIGNATURE**

PROVIDER NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

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