MIRAMONTE SCHOOL
1175 ALTAMEAD DRIVE, LOS ALTOS, CA 94024
PHONE 650.967.2783 FAX 650.967.0833

STUDENT MEDICAL RECORD

This form is to be completed by the family physician and kept on file at the school for all children (a) entering this school for the first time, and (b) at Grade Seven. This should include the Scoliosis examination for Grade 7 students.

NAME: _____ BIRTH DATE: _____ (MONTH) _____ (DAY) _____ (YEAR)

ADDRESS: _____ STUDENT SOCIAL SECURITY #: _____ - _____ - _____

CITY/STATE/ZIP: _____ NAME OF FATHER: _____

GRADE: _____ NAME OF MOTHER: _____

HISTORY: Past illnesses and allergies. Please check those he/she has had:

Cancer	_____	Heart Disease	_____	Whooping Cough	_____	Insect Bites	_____
Chicken Pox	_____	Measles	_____	Other	_____	Penicillin	_____
Diabetes	_____	Rheumatic Fever	_____	Ear Infections	_____	Other Drugs	_____
Diphtheria	_____	Scarlet Fever	_____	Allergies, Asthma	_____		
Epilepsy	_____	Tuberculosis	_____	Hay Fever	_____		

IMMUNIZATIONS: Must be verified by provider signature or stamp

DPT SERIES	Date	Signature/ Stamp
DPT 1		
DPT 11		
DPT 111		
DPT Booster		
DPT Booster		
DPT Booster		

POLIO SERIES	DATE	Signature/ Stamp
Polio 1		
Polio 11		
Polio 111		
Polio Booster		
Polio Booster		

Dtap Booster must be given after 7th birthday

Dtap Booster	Date	Signature/ Stamp

MMR	Date #1	Signature/ Stamp	Date #2	Signature/ Stamp
Measles				
Mumps				
Rubella				

HEPATITIS B	Date	Signature/ Stamp
Hepatitis B 1		
Hepatitis B 2		
Hepatitis B 3		

VARICELLA	Date	Signature/ Stamp
Varicella Immun.		
OR has had Chicken Pox		

MANTOUX TB TESTING: This test **must be Mantoux TB Test. Provider must supply all the information below.**

Date Given	Date Read	Read By	Mm induration	Positive/Negative

A POSITIVE MANTOUX TB TEST REQUIRES A CHEST X-RAY.

Film date: _____ / _____ / _____ Impression: _____ Normal _____ Abnormal

Person is free of communicable tuberculosis: _____ Yes _____ No

Signature/Agency: _____

An official record of immunization must accompany this medical record for all students entering school for the first time in the United States regardless of age level. Records considered official are:

- California State Immunization Record
- Official Immunization Record from another state
- School Immunization Record
- Health Provider Record: Physician or County Health Department – must have signature, stamp or initials next to each date

PHYSICIAN'S EXAMINATION

Height: _____ Weight: _____ Blood Pressure: _____

	Normal	Abnormal	Not Examined	
Skin				
Eyes, vision, glasses				
Ears, hearing				
Nose and throat				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen – enlargement				
tenderness				
hernia				
Spine, back				
Scoliosis – Grade 7				
Posture				
Extremities				
Genito-urinary				
Nervous System, reflexes				

Nutritional status and general appearance of the child: _____

_____

Recommendations for additional medical or dental care: _____

_____

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.

_____ Yes _____ No

If a 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: _____