



Victor Valley Seventh-day Adventist School

Where Excellent Education and Core Christian Concepts Meet

17137 Crestview Drive, Victorville, CA 92395 (760) 243-4176 Fax: (760) 245-5606 vvsda.com

STUDENT MEDICAL RECORD

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file. In the event of a medical emergency, the designated staff will retrieve the form for the medical professional treating your child.

Name _____ Birth Date _____

Address _____

_____ Social Security Number _____

Name of Father _____ Name of Mother _____

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

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

Explain briefly factors such as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience.

Indicate physical problem by a check mark: Hearing () Heart () Sight () Speech ()

Other _____
SPECIFY

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. Records considered official are:

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

LABORATORY RECORD

TB SKIN TEST

Type *	Dates Given	Given by	Date Read	Read By	mm indur	Impression
PPD Mantoux	/ /		/ /			Pos
Other _____	/ /		/ /			Neg
PPD Mantoux	/ /		/ /			Pos
Other _____	/ /		/ /			Neg
PPD Mantoux	/ /		/ /			Pos
Other _____	/ /		/ /			Neg

CHEST X-RAY Film date: ____/____/____ Impressing: normal abnormal
Person is free of communicable tuberculosis yes no

Signature/Agency _____



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PHYSICIAN'S EXAMINATION *

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	Explain Abnormalities
Skin				_____
Eyes, Vision, Glasses				_____
Ears, Hearing				_____
Nose and Throat				_____
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 _____

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 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 _____

Physician's Address _____

- 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 of Education.