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
Diptheria	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 Other ______	/ / / /		/ / / /			Pos Neg
PPD Mantoux Other ______	/ / / /		/ / / /			Pos Neg
PPD Mantoux Other ______	/ / / /		/ / / /			Pos 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.**