



MEDICAL INFORMATION

Adapted from VI Department of Human Services

Child Name _____

Birth Date: _____

Height: _____ Weight: _____

Examination Date: _____

Codes
O: Normal
X: To be Watched
XX: Needs Medical Attention
XXX: Immediate Attention

General Appearance

Nutrition _____	Nose _____	Lungs _____	Malformation _____
Head _____	Throat _____	Chest _____	Abdomen _____
Eyes _____	Heart _____	Tonsils _____	Genitalia _____
Ears _____	Skin _____	Teeth _____	Adenoids _____

Immunization

Polio:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
DPT:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
MMRI:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
MMRII:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
HIB:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
HEP B:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
VAR:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____
Tuberculin Test:	Dates (1) _____	(2) _____	(3) _____	(4) _____	(5) _____

History of Diseases

German Measles _____ Mumps _____ Polio _____ Measles _____ Chicken Pox _____ Whooping Cough _____

Other diseases and illnesses, including history of allergies:

Family History of Diseases

Parasites	YES _____	NO _____	Explanation _____
Tuberculosis	YES _____	NO _____	Explanation _____
Diabetes	YES _____	NO _____	Explanation _____
Other	YES _____	NO _____	Explanation _____

Athletic Participation

All Sports _____	Cross Country _____	Swimming _____	Volleyball _____
Badminton _____	Football _____	Soccer _____	Wrestling _____
Baseball _____	Gymnastics _____	Tennis _____	Other: _____
Basketball _____	Softball _____	Track _____	

Does the student have any known medical problems or significant medical history that could interfere with physical activities, such as physical education, athletics or certain field trips taken by the school? If yes, please explain:

Does the student have any known medical problems or significant medical history that could interfere with the activities of the normal school day? If yes, explain:

Is the student on any medication during school hours or that needs to be administered during school hours? If yes, please explain:

Physician Information & Recommendation

Name of Doctor: _____ Phone Number: _____

Doctor's Address: _____

I have found the above named child free of communicable and contagious diseases: YES _____ NO _____

I recommend this child for school: YES _____ NO _____ for participation in athletics: YES _____ NO _____

Doctor's Signature: _____ Date: _____

Emergency Medical Authorization

In the case of an emergency, if the legal guardian(s) cannot be reached, Giff Hill School will contact any additional person(s) to whom the legal guardian(s) has granted consent to act as the interim guardian. Please list any interim guardians below.

1. _____
Name Relationship to Student

_____ Home Phone Work Phone Cell Phone

2. _____
Name Relationship to Student

_____ Home Phone Work Phone Cell Phone

Any change in the above contact information should be promptly reported to the school.

_____ Parent/Guardian Signature Date