MEDICAL FORM

Student Health Information & Medical Examination Record

FOR STUDENT RECORDS

Student Name: _____

Class / Year Applying For: _____

Date Submitted: _____

Parent / Guardian Contact: _____

This form is to be completed and submitted as part of the admissions health record.

HEALTH INFORMATION

(To be completed by a Medical Physician).

These health forms are to be provided no later than the student's first day at school along with the application.

Please answer the following regarding the health of your child.

Student's Name:_____ Age:_____ Grade:_____ Sex: M____ F____

Date of Birth:_____ Nationality:_____ Home Phone:_____

Preferred Hospital:_____ Physician's Name:_____ Phone No:_____

Relatives/Friends to pick up sick or injured child if parents cannot be contacted:

1st Name:_____ Phone No:_____

2nd Name:_____ Phone No:_____

Existing Medical Conditions (check all that apply) History with any of the following conditions?

- ☐ Asthma (if yes, complete asthma section,
- ☐ Hay Fever
- ☐ Attention-Deficit/Hyperactivity Disorder
- ☐ Emotional/Behavioral Problems
- ☐ Allergies (if yes, fill allergies section below)
- ☐ Persistent Nose Bleeds
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Hepatitis
- ☐ Hearing Impairment
- ☐ Heart Problems
- ☐ Visual Impairment
- ☐ Migraine(s)
- ☐ Sickle Cell Disease
- ☐ Other_____

_____ _____

Allergies

Allergy to: (specify) Food_____ Medication_____

Insect Bite_____ Other(s)_____

Severity of your child's allergic reaction (circle one): Mild_____Moderate_____ Severe_____

Signs of your child's allergic reaction (check all that apply):

Hives_____ Watery Eyes_____ Wheezing_____ Coughing_____

Tightness in the Throat_____ Difficulty in Breathing_____

Other signs (describe)_____

Treatment for allergies_____

Name of Medication(s)_____

Dose_____

International Community College

MEDICAL FORM

HEALTH INFORMATION

PHYSICAL EXAMINATION REPORT (To be completed by a Medical Doctor/physician)
Student's Name:_____ Age:_____
Height (meters):_____ Weight:_____ Blood Pressure:_____ Pulse_____
Urinalysis _____ Sickling Status: _____Positive_____Negative (if positive, what kind _____
Vision Right:_____ Left:_____ Does student wear corrective eyeglasses? _____Yes _____No
Hearing Right:_____ Left:_____

SYSTEM EXAMINATION	COMMENTS ABOUT FINDINGS
General Appearance	
Ear, Nose and Throat	
Mouth/Teeth	
Skin	
Abdomen and Gastrointestinal Tract	
Cardiopulmonary (Heart and Lungs)	
Neurological	
Speech impairment	
Spine and other Mmuscle or skeletal issues	
Any abnormal physical findings, if any (summary):	

Specifically describe conditions that would identify the child as having a disability and/or require an educational evaluation, environmental adjustment, or activity restrictions:

Any significant medical history: _____
Referrals, recommendations, and comments:
I hereby certify that I have personally examined the applicant and reviewed the medical history.
Name : _____ Title:_____Hospital:_____
Signature: _____ Date:_____
Address: _____ Telephone:_____

Indicate any medication child must take at school:_____
(Medications must be provided to the Administrative Secretary I)

Signature of Parent or Legal Guardian:_____ **Date:**_____