

Name of Student _____
 (Last) (First)

(Stamp or type name of school here)

Bay Knoll Adventist School
2639 Ridge Road East
Rochester, NY 14622

TO THE EXAMINING PHYSICIAN: In order for the student's progress to be adjusted to his physical condition, and for sound health counseling to be given to him, it is necessary for the school to have a report of his health examination. This report will be held in confidence and used only for the protection and aid in his education. Kindly record on this form the findings of your examination, and especially, your recommendations to the school. Thank you.

MEDICAL EXAMINATION OF ELEMENTARY SCHOOL PUPIL BY PHYSICIAN

(To be filled in by the physician)

Name _____ Age _____ Address _____ School _____ Grade _____ Date of Examination _____	IMMUNIZATION STATUS <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 25%;">Date Last Given</th> <th style="width: 25%;">Recommended</th> </tr> </thead> <tbody> <tr> <td>Smallpox</td> <td></td> <td>Every Five Years</td> </tr> <tr> <td>Diphtheria</td> <td></td> <td>Booster Every 3 years</td> </tr> <tr> <td>Tetanus</td> <td></td> <td>Boosters at Discretion</td> </tr> <tr> <td>Polio</td> <td></td> <td>of Private Physician</td> </tr> </tbody> </table>		Date Last Given	Recommended	Smallpox		Every Five Years	Diphtheria		Booster Every 3 years	Tetanus		Boosters at Discretion	Polio		of Private Physician
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Polio		of Private Physician														

1. Significant illnesses, accidents, operations, congenital defects, family history, etc.: _____

2. Significant factors in home situation: _____

3. Please indicate below, by a check (x) in the column on the left, any positive findings on medical examination, or any handicapping disability, and describe fully in section on lower right. (If no check appears, condition will be assumed to be normal). Be sure laboratory findings are recorded in space provided:

	Skin	
	Eyes	
	Ears	
	Nose & Throat	
	Mouth	
	Glands	
	Heart	
	Lungs	
	Abdomen	
	Hernia	
	Extremities	
	Genito-Urinary	
	Nutritional Status	

Laboratory results:

CBC

Urinalysis

Description:

Treatment advised:

Vision: R _____ L _____ Hearing R _____ L _____ Tuberculin Test: _____
 Chest X-ray (if done): _____ X-ray findings: _____

4. Specify medical recommendations to school for academic and activity program:

Examining Physician:

Address:

HEALTH INVENTORY

(To be filled in by parent, before examination by physician)

1. Name of student _____ Age _____ Date of Birth _____
(year, month, day)

Address _____ Phone number _____

Father's name _____ Mother's name _____

Whom to notify in case of illness (give addresses and phone numbers)

(A) _____ (B) _____

Does student live at home with: Parents Mother Father Other _____

Does student have coverage by accident or hospitalization policy? (state type) _____

2. Past illnesses (please check those student has had):

_____ Measles	_____ Scarlet fever	_____ Heart disease
_____ Whooping Cough	_____ Diphtheria	_____ Chorea (St. Vitus' Dance)
_____ Polio	_____ Chicken pox	_____ Epilepsy
_____ Rheumatic Fever	_____ Diabetes	_____ Frequent colds (No. per year)
		_____ Hay Fever or Asthma

List any other serious illnesses, operations, or injuries, and age when occurred:

3. Has this student ever been around anyone known to have tuberculosis? Yes No

Has he/she ever been skin tested for tuberculosis? Yes Year _____ No

Has he/she ever had a chest X-ray? Yes Year _____ No

4. When did the child last visit the dentist? Date: _____

5. Has the student had his eyes examined? Date: _____ By whom? _____

6. Comment on student's habits: How many hours sleep does he/she usually get? _____

Does he/she participate in outdoor activities? Not at all Moderately Continuously

Does he/she prefer reading or watching TV to the above? Yes No

Eating habits: Eats only at mealtime In between meals occasionally Frequently

7. List any other items helpful to the school program in planning for student's health:

Date:

Signature: