Immaculate Conception School

Medical Record

This information is confidential and becomes a part of the student's cumulative record.

Name_____ Address_____
School_____Grade_____Room_____ Date of Birth_____

HEALTH SCREENING:

Height_____ Weight_____ Visual Acuity: Right_____ Left_____
Hearing Acuity: Right_____ Left_____
Strabismus:_____ Color vision_____
Signature_____ Date of Exam_____

IMMUNIZATION REQUIREMENTS:

Section 3313.671 of the Ohio Revised Code requires children of school age to be immunized against diphtheria, whooping cough, tetanus, polio, rubeola, rubella, mumps and Hepatitis B.

DtaP, DPT, DT,					
Polio					
MMR					
Hepatitis B					
Varicella					
Hib					
TB Test		Results			
Tdap					
MCV4					

PHYSICAL EXAMINATION:

Surgical History:

Medical History:

Perinatal History:

Allergies:

Medications:

Head and Neck_____
BP_____
Orthopedic_____
Chest_____Heart_____
Lungs_____ Abdomen_____
Hernia_____Extremities_____
Neurological_____
Behavioral/Emotional_____
_____

Urinalysis	
Hemoglobin	
Sickle Cell	
Serum Lead	
Other Labs	

Please indicate any physical activity restrictions or required adaptations to physical education program:

Other Recommendations and Comments:

Date of Exam_____ Health Care Provider Signature_____
Phone_____ Provider printed name or stamp_____

Revised 02/2016