



MATER DEI CATHOLIC SCHOOL Medical Record For Students

Parents are to complete this side of form.

Child's Name _____

Mother or Guardian _____

Father or Guardian _____

Home Address _____
Street

Home Address _____
Street

City/State/Zip

City/State/Zip

Home Telephone _____

Home Telephone _____

Work _____
Company

Work _____
Company

Telephone

Telephone

Hospital Preference (Emergency only) _____

1. If your physician has approved the use of any non-prescription medications for your child you need to submit a copy of that prescription with this physical.

2. Does your child have any of the following? Answer with yes or no.

____ Allergies ____ Frequent sore throats/colds ____ Ear Aches

____ Skin Problems ____ Other: _____ Describe: _____

3. Have there been any major changes at home that might affect your child? ____ No ____ Yes, as follows:

4. Please provide additional information/special instructions that will help Mater Dei Catholic School staff care for your child:

5. Please give dates for ALL immunization series completed by your child in the space below.

		1	2	3	4	5
	DPT, DT*, TD, (*DT only if child is allergic to DTP)					
	POLIO					
	MMR					
single dose only	RUBEOLA (MEASLES)					
	MUMPS					
	RUBELLA (GERMAN Measles)					
	HIB (Hemophilus Infl. B) *RECOMMENDED					
	HBV (Hepatitis B Vaccine) *RECOMMENDED					
	VAR (Varicella-Chicken Pox) *RECOMMENDED					

This side is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments CR A Licensed Physician. Physician Assistant's may complete the Health Assessment and must include the signature of the Licensed Physician.

Past health history (Developmental – Illness – Hospitalization):

Allergies _____

Current Medications _____

Nutritional Status _____

Physical Examination:

Height: _____ Weight _____

Head _____

Abdomen _____

EENT _____

GU _____

Teeth _____

GYN _____

Heart _____

Skeletal _____

Lungs _____

Neurological _____

Screening Tests (Dates done and results):

Vision _____

TBC: Test _____

Hearing _____

Sickle Cell _____

Speech _____

HGB. _____

DDST _____

U.A. _____

Other: _____

Diagnosis:

Recommendation:

Do you see this child for regular health supervision: ____ yes ____ no

Signature of Licensed Physician or Nurse Approved by KDHE

Date

Print the name of the individual signing above

Address of Physician or Nurse – list street/city/state/zip code

Telephone Number