Entering Grade September ___ The Frisch School MEDICAL FORM **ALL STUDENTS**

Name of Child (Last, First, M.I.)	Birth Date (Mo/Day/Yr)	Sex ❑ Male ❑ Female
Parent Guardian	Name	Phone No.
	Address	

Vaccine Type	Date of Disease	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	6th Dose Mo/Day/Yr
Diptheria, Tetanus, Pertussis - DTP* (if DT or Td, indicate in corner box)							
Oral Polio Vaccine (OPV) If Salk Vaccine, indicate (IPV) in corner box							
MMR (Measles, Mumps & Rubella)							
Measles							
Rubella							
Mumps							
Hepatitis B							
Menactra							
Tdap							
Varicella / Chicken Pox							

DISEASE HISTORY	**Year**		**Year**		**Year**	**SURGERIES OR INJURIES**	**Year**
Allergies		Asthma		Otitis Media			
Drug Sensitivities		Chicken Pox		Rheumatic Fever			
Lyme Disease		Convulsive Dis.		Strep Infections			
Hepatitis		Diabetes		Mononucleosis			
Neuromusc. Dis.		Heart Disease		Other		Congenital Defects	

HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = Comments

Grade/Age								
Date								
Height								
Weight								
Blood Pressure								
Vision with glasses	R							
	L							
	Both							
Vision without glasses	R							
	L							
	Both							
Muscle Balance								

TB Screening (Mantoux Test) Date _____ Read _____ Results _____

Scoliosis Screening Results _____

Is the student on any medication? No/Yes: List the medications

_____

Your signature authorizes the school nurse to administer Tylenol to the student if necessary.

Student may participate in any sport _____

Doctor's Name _____

Telephone _____

Date of Exam _____

Doctor's Signature _____

Grade/Age								
Date								
Ears (otoscopic)								
Eyes								
Lymph Glands								
Thyroid								
Nose								
Throat								
Teeth-Mouth								
Heart								
Lungs								
Abdomen								
Hernia								
Genito-Urinary								
	Structural							
Orthopedic	Posture							
	Feet							
Skin (Non Comm.)								
Nutrition								
Nervous System								
Speech								
Other								
General Appearance								
SIGNATURE OF PHYSICIAN								

Date	Record: Findings and Recommendations of Physicians; Modification of School Program Referrals and Follow-up; Conference with Parents, Teachers; Counseling with student	Signature

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