

School Health Examination Record

School _____ Grade _____

Student _____ Birth Date _____
(Last Name) (First Name) (Middle)

Father or Guardian's Name _____ Place of Employment _____ Business Phone _____

Mother or Guardian's Name _____ Place of Employment _____ Business Phone _____

Physician's Name _____ Address _____ Office Phone _____

Describe any health conditions, severe injuries, illnesses, surgical procedures and hospitalizations your child has or had in the past (include allergies and/or reactions to medications, food or any other substance and the recommended treatment if the allergy is severe).

List any medications that your child takes daily or frequently.

Please add any comments or concerns you have about your child that you would like the school to be aware of.