

Medical Record Good Shepherd Lutheran School



Student Information

Student Name _____
Last First Middle Nickname

Home Address _____
If different from Mailing Address

Mother _____
Name Address Phone

Father _____
Name Address Phone

Insurance Company: _____ Policy No: _____

Physician/Hospital/Dentist Information

Family Physician:

Name _____ Address _____ Phone _____

Hospital Preference:

Name _____ Address _____ Phone _____

Family Dentist:

Name _____ Address _____ Phone _____

Allergies & Medications

Medication _____ Explain _____

Food Allergies _____

Insect Bites _____

Other Allergies _____

Other Special Concerns _____

Significant Personal History (Child)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Mumps | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Bone and joint |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Convulsions or Seizures |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Frequent Strep Infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Muscular Disorder | |

Other Conditions _____

If any preceding conditions are checked, please give special instructions for care: _____

Significant Family Health History (Parents and Siblings)

- Allergies Tuberculosis Cancer Diabetes
 Heart Disease Kidney Disorder Nervous Disorder Mental Disorder
Other (please specify) _____

I (We) Hereby Authorize:

- Release of above information to all Good Shepherd Lutheran School & Child Care Personnel and School Bus Drivers.
- The Principal or other School Personnel to call the Physician or Dentist names above if an emergency exists, or it is necessary, an alternate doctor.
- Permission for transporting my student if in need of emergency care.

Medical Consent:

In the case of illness or accident requiring medical care, you have my(our) permission to obtain such care from the nearest hospital and to release personal identifiable information regarding my(our) child. I(We) agree to pay all expenses incurrent in such emergency care.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Physical Examination
Good Shepherd Lutheran School



Height _____ % Weight _____ % Blood Pressure _____

	Normal	Abnormal	Comments
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nutritional Status	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional Status	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you wish to see this child again? Yes No If so, when _____

Are you referring this child to another professional? Yes No If so, when _____

Is this child on any medication? Yes No If so, what _____

Recommendations for Child's School Program

Date of Examination _____

Physician's Signature _____

Address _____ Phone _____