



6905 Given Road, Cincinnati, Ohio 45243
School Nurse Phone: (513) 979-0250

STUDENT MEDICAL RECORD FORM

This form is **REQUIRED** and must be completed and signed by a physician **ANNUALLY** for all students under the age of 6 years and new students, Early Childhood through 12th grade. This form must be on file prior to the first day of school or athletic practice.

MEDICAL HISTORY AND PHYSICAL EXAMINATION

Name:		(First)	(Middle)	(Last)
Date of Birth:		Date of Physical Exam: ____/____/____		
Gender:		Visual Acuity: R L		
Grade:		Corrective Lenses: Contacts None		
Height:	Weight:	Date of last eye exam: ____/____/____		
Pulse:	Blood Pressure:	Hearing Acuity: R L		
		Posture:		

Please check the appropriate boxes and explain any "Yes" answers below.	Yes	No	N/A
1. Has this student ever had any hospitalizations, surgeries, injuries, or serious medical illnesses?			
2. Does this student have any chronic physical problems?			
3. Are there any physician-recommended physical limitations regarding participation in athletic activities?			
4. Does this student have any drug, food, or environmental allergies? Action Plan: Yes ____ No ____			
5. Is there any history of syncope or loss of consciousness during physical activity?			
6. Does this student have any communicable diseases?			
7. Are any medications, food, fluoride supplements, or dietary restrictions prescribed? If yes, please specify below.			
8. Has this student lived in the US for 5 years or less? If yes, please specify which country(s) they have resided below			
Other Health Issues/any "Yes" listed above (please explain):			

IMMUNIZATION HISTORY (Attach a universal form from your physician). State law requires that you provide the month, day, and year of each immunization given. Failure to provide an immunization record within fourteen (14) days of school entrance may involve exclusion from school, as required by law (ORC 3313.671). Foreign-born students, recently arrived (within 5 years) from countries that have a high rate of Tuberculosis must provide documentation of wither a Mantoux Skin Test or QuatiFERON blood test.

I certify that I have on this date examined this student. On the basis of this examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason that would make it medically inadvisable for this student to compete in supervised athletic activities, except as noted above. I certify that the student is free from communicable disease.

Signature of Physician (**REQUIRED**):

Print or Stamp Address & Phone

Print Name:

Date: