

**Waldorf School of Princeton
Medical Records 2009-2010**

To be completed by Parent/Guardian (Kindly print)

Date _____

Child's Last Name _____ First Name _____ Middle Name _____

Father's Name _____ Mother's Name _____

Address _____

Date of Birth _____ Male _____ Female _____ Telephone # _____

Country of Birth _____

Emergency Contact: Name _____ Relationship _____

Address _____ Telephone # _____

HEALTH HISTORY

1. Illnesses with Dates:

Mumps	German Measles
Roseola	Chicken Pox
Mononucleosis	Step Throat
Rheumatic Fever	Lyme Disease

Other: _____

2. List any Surgeries, Injuries or Medical Conditions along with Dates:

3. Does your child have any of the following conditions? (give approximate year of diagnosis)

Drug Allergies	Neuromuscular Conditions
Food Allergies	Heart Conditions
Peanut Allergy	Congenital Conditions
Bee Sting Allergy	Seizures
Other Allergy	Asthma
Diabetes	Other

4. Does your child wear glasses? _____ Contact Lens? _____ Reason _____

5. Does your child use hearing aids? _____ Left _____ Right _____ Reason _____

6. Does your child use any type of prosthesis? _____ Reason _____

7. Is your child on any medication? _____ List Name of medication and specify condition for which medication is given: _____

8. Will your child require medications during school hours? _____

9. List Any Health Conditions or Problems we should be aware of: _____

Name, Address & Phone of Child's Physician: _____

Name, Address & Phone of Child's Dentist: _____

I give permission to share medical information with the appropriate school staff: Yes _____ No _____

Parent/Guardian signature: _____ Date: _____

Waldorf School of Princeton
Record of Physical Examination
To be completed by a health care provider. PLEASE SIGN AND DATE

Name of student: _____ Birth Date: _____

Gender: M / F (circle) Grade: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: (bpm) _____

Vision: R 20/___ L 20/___ Corrected: Y / N Glasses: Y / N Contacts: Y / N Hearing: R ___ L ___

Immunizations/Mantoux result: Complete reverse side or attach copy.

	Normal	Abnormal	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose			
Heart: Murmur/Rhythms			
Lungs: Auscultations/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (inc. Liver, spleen)			
Tanner Stage: Testes/Onset of Menses			
Hernia			
Neck/Back/Spine Range of Motion: Scoliosis:			
Upper Extremities			
Lower extremities			
Neurological: Balance & Coordination			
Romberg:			
Heel Walk:			
Tandem Walk:			
Nose Touch:			
Toe Walk:			

History of Illness/Injury: _____

Remarks/Impression/Summary: _____

ALLERGY: _____

MEDICATION: _____

May participate in school activities without limitations: _____ Yes _____ No

If not, specify limits: _____

Physician's Signature: _____ **Date of Exam** _____

Physician's Stamp _____ **(complete other side)**

Please complete or attach a copy.

Vaccine Type	Disease Date	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	6 th Dose Mo/Day/Yr
Diphtheria/Tetanus Pertussis, DPT	X						
Oral Polio (OPV) If Salk (IPVO) indicate	X						
MMR (Measles, Mumps & Rubella)	X						
Measles	X				Measles or Serology	Date	Titer
Rubella	X				Rubella or Serology	Date	Titer
Mumps	X				Mumps or Serology	Date	Titer
HIB							
Hep B							
Varicella							
Prevnar	X						
Hep A							
Flu	X						
Meningitis							
BCG	X						

TB Screening (Mantoux Test)	Chest X-Ray			Therapy
	Date	Result		
	Date	Normal	Abnormal	Case Reactor
Tested				Date Started
Read				Date Completed
Result (MM)				