MEDICAL INFORMATION FORM

Your child must have documented immunization records and receive a comprehensive physical examination each year before entering school. This form must be returned to St. Stephen's Episcopal School – Houston prior to the first day of school.

This form MUST be completed by a qualified licensed physician, nurse practitioner or physician's assistant.

Child's Name: _____ **Date of Birth**: _____

PHYSICIAN'S INFORMATION

Physician's Name: _____ Phone (_____)_____

Professional Office Address_____

City: _____ State: _____ Zip: _____

Specialist's Name: _____ Phone (_____)_____

Professional Office Address_____

City: _____ State: _____ Zip: _____

Hospital Affiliation: _____ Phone (_____)_____

Branch: _____ Address: _____ City: _____ State: _____ Zip: _____

Please list all prescription medications currently taking:

Name of Medication	Prescription	Dosage	Frequency	Notes
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

IMMUNIZATION RECORD *(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)*

DPT #1		POLIO		HepB #1		Hib #1		TB		IPV #1		Tdap	
DPT #2		POLIO		HepB #2		Hib #2		TB		IPV #2		MCV4	
DPT #3		POLIO		HepB #3		Hib #3		TB		IPV #3		HPV	
DPT #4		POLIO		PCV #1		Hib #4		TB		IPV #4			
DPT #5		POLIO		PCV #2		RV# 1		TB					
MMR #1		Hep A#1		PCV #3		RV#2		TB		Varicella			
MMR #2		Hep A#2		PCV #4		RV#3		Influenza		Varicella			

IMMUNIZATIONS WITHHELD:

Immunization_____ Reason_____

Immunization_____ Reason_____

Immunization_____ Reason_____

Immunization_____ Reason_____

Immunization_____ Reason_____

ALLERGIES: *please list the agent to which the child is allergic, the noted reaction and treatment required*

Agent	Reaction	Treatment

PHYSICAL EXAMINATION *(Please indicate abnormalities below)*

Child's Name: _____ **Date of Birth**: _____

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in. Body Mass Index (BMI): _____ BP_____

Examination included evaluation of the following:

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	☐	☐	☐	Neurological	☐	☐	☐	Skin	☐	☐	☐
Lungs	☐	☐	☐	Abdomen	☐	☐	☐	Genital	☐	☐	☐
Heart	☐	☐	☐	Extremities	☐	☐	☐	Urinary	☐	☐	☐
Spine	☐	☐	☐	Emotional	☐	☐	☐	Psychological	☐	☐	☐
Additional	☐	☐	☐	Additional	☐	☐	☐	Additional	☐	☐	☐
_____				_____				_____			

Developmental Screening:

Assessed for:	Assessment Method:	Within Normal	Concern identified	Referred for Evaluation
Emotion/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screening:

❑ Permanent Hearing Loss previously identified: ___Left ___Right

❑ Hearing aid or other assistive device

Vision Screening:

❑ With Corrective Lenses ❑Referred to eye doctor

ABNORMALATIES WITH PHYSICAL EXAMINATION

_____

_____

_____

Diseases *(please indicate the date of any disease below)*

Disease	Date	Treatment	Notes
Chicken Pox			
Mumps			
Rubeola			
Rubella			
Scarlet Fever			
Diphtheria			
Other			
Other			

Examination Summary:

❑ Well child; no conditions identified of concern to school program activities

❑ Conditions identified that are important to schooling or physical activity *(complete sections below and/or explain here):*

_____

_____

_____

Recommended allergy treatment:

❑ none ❑ epi pen ❑ other: _____

Additional recommendations:

❑ Individualized Health Care Plan needed *(e.g., asthma, diabetes, seizure disorder, severe allergy, etc.)*

❑ Restricted activity specifications:

_____

_____

_____

Developmental Evaluation: ❑ Has IEP ❑ Further evaluation needed for:

_____

_____

_____

Medication:

❑ Child takes medicine for specific health condition(s) ❑ Medication must be given and/or available at school

Special Diet:

_____

_____

_____

Special Needs:

_____

_____

_____

Additional comments:

_____

_____

_____

Health Care Professional's Certification *(please write legibly or stamp):*

Signature: _____ Printed Name: _____

Practice/Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____-_____-_____ Fax: _____-_____-_____

Email: _____ Today's Date: ____/_____/_____

MEDICAL RELEASE

I hereby give my permission to St. Stephen's Episcopal School to secure emergency medical and/or emergency surgical treatment for the above-named minor child while in their care. Non-emergency medical treatment or elective surgery is not included in this authorization.

Signature of Parent or Legal Guardian _____ Date _____