PRIMARY / SECONDARY / HIGH SCHOOL MEDICAL FORM

TO BE COMPLETED BY A HEALTHCARE PROVIDER

Kits4Kids International School Madagascar

STUDENT INFORMATION

STUDENT NAME :	DATE OF BIRTH (dd/mm/yyyy) :
PARENT / GUARDIAN NAME (S) :	SCHOOL ATTENDED :
HEALTHCARE PROVIDER / DOCTOR :	DATE OF EXAMINATION :
PERTINENT FAMILY MEDICAL HISTORY :	

CURRENT HEALTH ISSUES :

Y N

[ ] [ ] ALLERGIES : *Please list :* MEDICATIONS : _____ FOOD : _____ OTHER : _____

HISTORY OF ANAPHYLAXIS TO _____ EPI - PEN® : [ ] YES [ ] NO

[ ] [ ] ASTHMA : ASTHMA ACTION PLAN [ ] YES (*Please attach*) [ ] NO

[ ] [ ] DIABETES : [ ] TYPE I [ ] TYPE II

[ ] [ ] ATTENTION DISORDER (*Please specify*) MEDICINES : [ ] YES (*Please specify* : _____) [ ] NO

[ ] [ ] SEIZURE DISORDER : _____

OTHER (*Please specify*) : _____

CURRENT MEDICATIONS (*if relevant to the student's health and safety*)

Please circle those administered in school; a separate medication order form is needed for each medication administered in school.

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL
GENERAL APPEARANCE	[ ]	[ ]
SKIN	[ ]	[ ]
H.E.E.N.T	[ ]	[ ]
DENTAL / ORAL	[ ]	[ ]
LUNGS	[ ]	[ ]
HEART	[ ]	[ ]
ABDOMEN	[ ]	[ ]
GENITALIA	[ ]	[ ]
NEURO	[ ]	[ ]
EXTREMITIES	[ ]	[ ]
MUSCULOSKELETAL	[ ]	[ ]
BLOOD PRESSURE	[ ]	[ ]

HEIGHT : cm

WEIGHT : kg

HEARING : R L

VISION : R L

POSTURAL SCREENING :
[ ] SCOLIOSIS [ ] KYPHOSIS
[ ] LORDOSIS

IMMUNIZATION COMPLETE :[ ]Y [ ] N

Please attach complete immunization record. If no, give reason.

ADDITION TESTS REQUIRED

[ ] TB Test date : _____

[ ] LEAD Test date : _____

[ ] OTHER: _____

Test date : _____

SUMMARY OF FINDINGS

[ ] WELL CHILD, NO CONDITIONS IDENTIFIED OF CONCERN

[ ] CONDITIONS IDENTIFIED THAT ARE OF CONCERN TO SCHOOL AND / OR PHYSICAL ACTIVITY

Complete sections below and explain here :

LABORATORY RESULTS

LEAD : _____ DATE : _____ LEAD : _____ DATE : _____

OTHER : _____ DATE : _____

This student has the following problems that may impact his / her educational experience:

[ ] VISION [ ] HEARING [ ] SPEECH / LANGUAGE

[ ] FINE / GROSS MOTOR DEFICIT [ ] EMOTIONAL / SOCIAL

[ ] BEHAVIOR [ ] OTHER : _____

COMMENTS AND RECOMMENDATIONS :

[ ] PHYSICAL EDUCATION EXCUSE [ ] ALLERGY / ASTHMA ACTION PLAN

[ ] ASTHMA MEDICATION ORDER FORM [ ] MEDICATION ORDER FORM

PROVIDER INFORMATION

PROVIDER'S NAME :	PHONE :	
ADDRESS :	CITY :	COUNTRY :

_____ _____

PROVIDER'S SIGNATURE DATE

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.