

GARFIELD HEIGHTS CITY SCHOOLS

SCHOOL ENTRANCE MEDICAL RECORD AND IMMUNIZATION INFORMATION

School: _____ Grade: _____
Name: _____ Birthdate: _____
mo/day/year
Address: _____ Telephone: _____
Name of Physician: _____ Physician Telephone: _____
Name of Dentist: _____ Dentist Telephone: _____

MEDICAL HISTORY (Give a year)

Chicken Pox _____	Scarlet Fever _____	Eczema _____	Diabetes _____
Measles _____	Convulsions _____	Ear Infections _____	Heart Disease _____
Mumps _____	Strep Infection _____	Hearing Problem _____	Kidney Disease _____
Rubella _____	Hay Fever _____	Speech Problem _____	Other _____

Any known physical handicaps (explain) _____
Allergies of asthma (explain) _____
Emergency treatment required (explain) _____
Bee sting allergy: _____ Emergency treatment required (explain): _____
Hospitalization (reasons and dates) _____
Injuries or serious illness (explain) _____
Visual difficulty _____ Wear glasses? _____
Is your child currently on any medication? _____
Reason for medication: _____ Name of medication: _____
Other Health Problems: _____

FAMILY HISTORY (serious illness in immediate family)

Diabetes _____ Tuberculosis _____ Heart Disease _____ High Blood Pressure _____

IMMUNIZATIONS (Give Month/Day/Year)

DPT: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

POLIO: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
mo/day/year mo/day/year mo/day/year mo/day/year mo/day/year

MMR (on or after first birthday) 1. _____ MMR (before Kindergarten) 2. _____
mo/day/year mo/day/year

HIB: (Dates) _____ VARICELLA 1. _____ 2. _____
(Chicken Pox) mo/day/year mo/day/year (before Kindergarten).

HEP. B.: 1. _____ 2. _____ 3. _____
mo/day/year mo/day/year mo/day/year

TUBERCULIN TEST (type): _____ Date: _____ Results: Positive Negative
Other (specify type and dates: _____

Tdap Booster: 1. _____ (REQUIRED for 7th grade entrance)
mo/day/year

Signature of Parent or Guardian: _____ Date: _____