SPRING VALLEY ACADEMY
KNOW FOLLOW SHARE JESUS

MEDICAL EVALUATION RECORD of STUDENT

(with Physician's Recommendations)

STUDENT's NAME: _____ Birthdate: _____ Sex: ____ GRADE ____

Medical Conditions that may cause emergencies at school: (allergies, asthma, diabetes, epilepsy, fainting, other)

_____

_____

Immunizations are required by law (ORC 3313.671) Update and record required vaccines

_____ **Medical Exemption** reason _____

_____ **Personal / Religious Conviction Exemption** (risks discussed with physician and waiver signed by parent)

Fill in* Immunizations *or attach a record					
TYPE	DATE (Mo/Day/Yr)				
DTaP					K
TdaP	7th	1st MCV4 Menactra/Meningococcal	7th	2nd MCV4 Menactra/Meningococcal	12th
Polio				K	
Hepatitis B				Hep A	Hep A
MMR		K			
Varicella		K			
Hib					
Other					
Tuberculin Test: Date _____ Type _____ Result _____					
Chest X-ray: Date _____ Result _____					

Past Medical History: Please list any illnesses, accidents, operations, or congenital defects that may limit the student's participation in classroom or physical education activities. List conditions and restrictions: _____

_____

_____

Please list **Current Chronic Conditions** (mental or physical) that require periodic monitoring: _____

At what intervals are rechecks needed? _____

MEDICATIONS Prescribed:_____

Please list medications REQUIRED at School:Medication: _____Dose: _____ Frequency: _____

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Referrals Needed: (Dental, Vision, Hearing) Please list if any referrals were made: _____

Are there any **vision deficit**s noted? _____ Does the student require glasses or contacts? _____

Are there any **auditory / hearing deficits** noted? _____ Does the student require hearing aids or devices? _____

Accommodations or Recommendations for school:(Please list ways the school could assist the student with special needs)

DATE of EXAMINATION: _____ **Physician's signature** _____

Office Stamp: _____ Physician's PRINTED Name _____