HEALTH & MEDICAL RECORD QUESTIONNAIRE

Student Information

Student's Name: ______________________________

Address: ______________________________

City: ______________________ Country: ______________________

Telephone: ______________________________

Physician Information

Physician's Name: ______________________________

Address: ______________________________

City: ______________________ Country: ______________________

Telephone: ______________________________

Medical History

Have you had? Please check all that apply.

- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Epilepsy
- ☐ Concussion or Head Injuries
- ☐ Rheumatic Fever or Heart Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Sexually Transmitted Disease
- ☐ Strokes
- ☐ Tuberculosis
- ☐ Broken Bones

Have you ever been hospitalized, had surgery, or been under extended Medical care?

No ☐ Yes ☐ If yes, for what reason? ______________________________

____

Systemic Overview & History

Do you have the following? Please check all that apply.

- ☐ Eye Disease or injury
- ☐ Headaches
- ☐ Chronic sinus trouble
- ☐ Hearing aids
- ☐ Eyeglasses
- ☐ Glaucoma
- ☐ Ear disease
- ☐ Dizziness
- ☐ Double vision
- ☐ Nosebleeds
- ☐ Impaired hearing
- ☐ Episodes of unconsciousness

Skin:

- ☐ Abnormal pigmentation
- ☐ Skin disease, hives, eczema
- ☐ Jaundice
- ☐ Frequent infection or boils

Neck:

- ☐ Stiffness
- ☐ Thyroid trouble
- ☐ Enlarged glands

Respiratory:

- ☐ Spitting up blood
- ☐ Asthma
- ☐ Chronic or frequent cough

Have you been in good general health most of your life?

No ☐ Yes ☐ If not, please explain. ______________________________

____

Allergies and Sensitivities

Is there a history of skin reaction or other reaction or sickness following injections or oral administration of:

- ☐ Penicillin or other antibiotics
- ☐ Morphine, Codeine, Demerol, other narcotics
- ☐ Aspirin, empirin or other pain remedies
- ☐ Tetanus, antitoxin or other serums
- ☐ Any foods, such as egg, milk or chocolate

List:

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- ☐ Novocaine or other anesthetics
- ☐ Sulfa drugs
- ☐ Adhesive tape or latex (circle)
- ☐ Iodine or merthiolate
- ☐ Any other drug or medication

List:

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Pet/AnimalAllergies No ☐ Yes ☐

Please explain.

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Other allergies? No ☐ Yes ☐

Please explain.

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Mental Health

Have you ever received any medical attention or counseling for psychological or emotional issues? No ☐ Yes ☐

*If yes, please explain.*____

____

Have you ever received pharmacological treatment (medication) for a psychological or emotional issue? No ☐ Yes ☐

If yes, please explain. ____

____

Medications

Are you currently taking medication for any reason? No ☐ Yes ☐

If yes, please list. ____

____

____

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for purposes of processing this application.

Signature of Student: ______________________________ **Date:** ____________

Signature of Parent: ______________________________ **Date:** ____________

MEDICAL EXAMINATION FORM

to be completed by Family Physician

Physician Information

Physician's Name: ______________________________

Address: ______________________________

City: ______________________ Country: ______________________

Telephone: ______________________________

Examination Results

Normal	Check each item	Abnormal
☐	Head, Face, Neck, Scalp	☐
☐	Nose	☐
☐	Sinuses	☐
☐	Mouth and Throat	☐
☐	Ears- General (interior & exterior)	☐
☐	Ear Drums (perforated)	☐
☐	Eyes	☐
☐	Ophthalmoscopic	☐
☐	Pupils	☐
☐	Ocular Motility	☐
☐	Lungs and Chest	☐
☐	Heart	☐
☐	Vascular System	☐
☐	Abdomen and Viscera	☐
☐	Anus and Rectum	☐
☐	Endocrine System	☐
☐	G – U System	☐
☐	Upper Extremities	☐
☐	Feet	☐
☐	Lower Extremities	☐
☐	Spine, other Musculoskeletal	☐
☐	Body Marks, Scars, Tattoos	☐
☐	Skin Lymphatics	☐
☐	Neurologic	☐
☐	Psychiatric	☐
☐	Pelvic (female only)	☐

Examination:

☐ vaginally ☐ rectally

Physical and Labratory Results

Height: ______________ Weight: ______________

Color Eyes: ______________ Build: ☐ slender ☐ medium ☐ heavy

Hair Color: ______________

BLOOD PRESSURE

Sitting: ____________ Recumbent: ______________ Standing: ______________

PULSE

Sitting: ____________ After Exercise: ____________ 2 minutes After : ____________

LABORATORY FINDINGS

Urinalysis (A.Specific Gravity): Albumin ________ Sugar ______________

Serology (Specify Test): ______________ Blood type & RH Factor ________

Tuberculosis (Clearance must be within 6 months)

Chest X-Ray Date: ______________ Positive or Negative: ____________

Skin Test Date: ______________ Positive or Negative: ____________

Medications

Are you currently taking medication for any reason? No ☐ Yes ☐

If yes, please list. ______________________________

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____

Physician Signature

Signature of Physician: ______________________________

Date of Exam: ______________

Were there any infectious or transmittable diseases found? No ☐ Yes ☐

If yes, please explain ______________________________

Undisclosed information or inaccuracies in information provided could result in dismissal from The Rock School.

Signature of Student: ______________________________ **Date:** ____________

Signature of Parent: ______________________________ **Date:** ____________

Student's name:______________________________

IMMUNIZATION RECORD FOR SCHOOL ADMITTANCE

to be completed by Family Physician

Immunization Requirements

Pupils enrolled in kindergarten through grade 12 (in the United States) are required to have written proof on file at their public or nonpublic school that they have been immunized against DPT (diphtheria, pertussis, tetanus), poliomyelitis, measles, mumps and rubella and Hepatitis B. Failure to do so is cause for exclusion from school. Required immunizations may vary from state to state.

MINIMUM IMMUNIZATION REQUIREMENTS:

Five or more doses of DPT, DT (Pediatric), TD (Adult) vaccine or a combination thereof.
Three or more doses of trivalent oral polio vaccine (TOPV).
Two doses measles vaccine.
Two doses mumps vaccine.
Two doses rubella vaccine.
Three doses of Hepatitis B
Two doses of Varicella (Two doses required if first doses issued after thirteenth birthday)

If the final dose of any of the above vaccines occurs before the third birthday, a booster shot is required.

Immunization Record

DPT	1. ______ Date	2. ______ Date	3. ______ Date	4. ______ Date	5. ______ Date	*Booster if Required* ______ Date
TOPV	______ Date of Disease	1. ______ Date	2. ______ Date	3. ______ Date	*Booster if Required* ______ Date	
Measles	______ Date of Disease	1. ______ Date	2. ______ Date	*Booster if Required* ______ Date		
Mumps	______ Date of Disease	1. ______ Date	2. ______ Date	*Booster if Required* ______ Date		
Rubella	______ Date of Disease	1. ______ Date	2. ______ Date	*Booster if Required* ______ Date		
Hepatitis B	______ Date of Disease	1. ______ Date	2. ______ Date	3. ______ Date		
Varicella (chickenpox)	______ Date of Disease	1. ______ Date	2. ______ Date	3. ______ Date		

Physician Signature

Signature of Physician: ______________________________ Date: __________

Any immunizations not available in your country are available here, but they are expensive and are not covered by insurance. The student must be prepared to pay for any immunizations they receive in the USA. Please make every effort to obtain all immunizations before your departure from your home country.