

Renaissance Academy Charter School

Student Medical Record

Child's Name: _____ DOB: _____

Parent/Guardians: _____ Phone: _____

Physician's Name: _____ Phone: _____

Address: _____
Street City State Zip Code

To be completed by the child's physician

Date of examination: _____ Child's Age: _____ Height: _____ Weight: _____

Immunization Dates

Please complete dates below or attach immunization record:

Diphtheria: _____

Poliomyelitis: _____

Pertussis: _____

Hepatitis B: _____

(whooping cough)

Chicken Pox: _____

Tetanus: _____

Tuberculin Test: _____

Measles: _____

Smallpox: _____

Mumps: _____

_____ : _____

Rubella: _____

_____ : _____

History of Diseases

Measles: _____

Chickenpox: _____

Mumps: _____

German Measles: _____

Whooping Cough: _____

_____ : _____

Physician's Report

Please report on the overall health and development of this child and include any concerns or important information. _____

I have examined _____ and find him/her to be in good health for admission to your school, and participation in all school and sports activities.

Physician's Signature: _____ Date: _____