DAKOTA ADVENTIST ACADEMY

MEDICAL EVALUATION RECORD OF STUDENT
(WITH PHYSICIAN'S RECOMMENDATIONS)

This confidential information is requested so that the school and parent can work together to meet the physical, intellectual and emotional needs of the student. A physician must complete and sign this document.

Student's Name _____ Birth date _____ Sex ___

Address _____ Father _____

_____ Mother _____

School _____ Grade ____ Examination Date _____

1. Is this student subject to emergency intervention for epilepsy, diabetes, fainting, allergies, asthma, other? Yes No - Explain reactions and interventions _____

   _____

   _____

2. Significant illnesses, accidents, operations, congenital defects, family history, etc. _____

   _____

3. Has the student been screened for hearing, vision or dental problems? Results _____

   _____

4. Please indicate below, by a check in the column on the left, any positive findings on medical examination, or any handicapping disability and describe fully in section on right.

	SKIN
	EYES
	EARS
	NOSE AND THROAT
	MOUTH
	GLANDS
	HEART
	LUNGS
	ABDOMEN
	HERNIA
	EXTREMITIES
	GENITO-URINARY
	NUTRITIONAL STATUS

Description:

Treatment advised:

Vision (if done) R ___ L ___

5. Specify medical recommendations to school for academic and activity program:

(Complete immunization form on other side.)
IMMUNIZATION: North Dakota law prohibits students from attending school who have no up to date record of immunizations on file in that school.

Requirements:

1. Students should have received 5 Diphtheria-Tetanus-Pertussis (DTP) and 4 Oral Polio (OPV) by school entry; however, four DTP and 3 OPV vaccinations are acceptable if the last dose was received between 4 and 6 years of age.
2. Students need 2 Measles-Mumps-Rubella (MMR) immunizations prior to attending college.
3. Students should have Tetanus-Diptheria (TD) booster every ten years.

TYPE OF VACCINE	1st Dose Month/Year	2nd Dose Month/Year	3rd Dose Month/Year	4th Dose Month/Year	Booster Month/Year	Booster (10 yrs after previous dose) Month/Year
Diptheria-Tetanus DIP Pertussis						
POLIO						
MEASLES						
RUBELLA			**HEPATITIS B**	**1.**		
				2.		
MUMPS				**3.**		

Tuberculin test Date _____ Result _____
Chest X-ray Date _____ Result _____

This student has received the required immunizations by me or validated from acceptable documents.
Signed _____ Date _____

This student is in the process of receiving the required immunizations this school year:

Signed _____ Date _____

If the student has not had the required immunizations for the reasons below please complete.

1. The physical condition of the above named student is such that immunizations would endanger life or health.
   Signed _____ Date _____

2. I, the guardian or parent of the above child, adhere to a belief whose teaching is opposed to such immunizations. It is hereby requested that the above named student be enrolled without immunizations.
   Signed _____ Date _____

School Physical Completed by:

Signed _____ M.D. Date _____