SALEM•KEIZER PUBLIC SCHOOLS

PUPIL MEDICAL RECORD
Confidential Information

STUDENT ID#	SCHOOL

Student Name: _____ Birthdate: _____ Grade: _____ Sex: M F

Parent/Guardian: _____ Work PH: _____ Home PH: _____

Email: _____ Cell PH: _____

Name of Healthcare Provider/Clinic: _____ Phone: _____

GUARDIAN'S EVALUATION OF STUDENT'S HEALTH

1. Has your student been **diagnosed by a healthcare provider** for any of the following? **If yes, please describe**.

   - ❑ ADD/ADHD _____
   - ❑ Allergy to: _____
     Is Epinephrine prescribed: ☐ Yes ☐ No
     Note: An additional form must be completed by a healthcare provider when Epinephrine is prescribed.
   - ❑ Asthma _____
     Note: An additional form must be completed by a healthcare provider when student is diagnosed with Asthma.
   - ❑ Bladder Disorder _____
   - ❑ Blood Disorder _____
   - ❑ Bowel Disorder _____
   - ❑ Cancer *Date:* _____
   - ❑ Concussion/Head Injury *Date:* _____
   - ❑ Diabetes ☐ Type 1 ☐ Type 2 *Date of diagnosis:* _____
   - ❑ Ear Disorder _____
   - ❑ Eye Disorder _____
   - ❑ Food Intolerance to: _____
   - ❑ Heart Condition _____
     Has this condition been repaired? ☐ Yes ☐ No *Date of repair*: _____
   - ❑ Seizure Disorder _____
   - ❑ Suppressed Immune System _____
   - ❑ Syndrome *Date of diagnosis:* _____
     Describe: _____
   - ❑ Other health problem *Date of diagnosis:* _____
     Describe: _____

2. Does your student have a physical handicap? ☐ Yes ☐ No *Describe:* _____
3. Has your student ever had an operation? ☐ Yes ☐ No *Describe:* _____
4. Has your student ever had a severe injury? ☐ Yes ☐ No *Describe:* _____
5. Is your student presently under a healthcare provider's care for a particular illness or condition? ☐ Yes ☐ No
   State nature of illness or condition: _____
6. Is he/she taking medication? ☐ Yes ☐ No *Reason:* _____
   Name of medication: _____
   Note: An additional form must be completed for all medications taken at school
7. Is your student able to participate in full activity at school? ☐ Yes ☐ No
   Note: An additional form must be completed by a healthcare provider when Yes is checked for activity restrictions.
8. Has your student been hospitalized recently? ☐ Yes ☐ No *Date:* _____ *Reason:* _____

PLEASE CALL THE NURSE HELPLINE AT (503)399-3376 IF YOU HAVE FURTHER QUESTIONS OR CONCERNS

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SIGNATURE OF PARENT/LEGAL GUARDIAN **DATE**