

In the name of Allah, Most Gracious, Most Merciful

**Me'raj Academy**

Pre-School-Kindergarten-Elementary

**HEALTH RECORD AND EXAMINATION FORM**

**Name of Student** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Part 1 — Parent Completes:**

**Required for all students (new and returning)**

\_\_\_\_\_ My child is able to participate in school playground and athletic activities without restrictions.

\_\_\_\_\_ The following conditions (e.g., illness, allergies, vision or hearing impairment, need for medication) may affect my child's school performance or restrict physical activities:

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**Condition of Health**

\_\_\_\_\_ Asthma \_\_\_\_\_ Hay Fever \_\_\_\_\_ Colds (frequent) \_\_\_\_\_ Tonsillitis \_\_\_\_\_ Skin Allergies

\_\_\_\_\_ Food allergies \_\_\_\_\_ Subject to headaches \_\_\_\_\_ Exposure to Tuberculosis

\_\_\_\_\_ Wears glasses (if so, date of last exam: \_\_\_\_\_ Operations (if so, dates and

reasons \_\_\_\_\_

\_\_\_\_\_ Dental needs \_\_\_\_\_

**Parent's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Part II — Physician completes:**

**Required for all new students and returning students who have had a change in their immunization or childhood disease status in the past 12 months. The physician or health examiner may use the form below or attach photocopies of the original records. A medical professional must sign documentation or bear the stamp of a doctor's office/health clinic or appear on the printed form of an HMO (e.g. Kaiser).**

| VACCINE  | Date Each Dose was given |                 |                 |                 |                 |
|--|--------------------------|-----------------|-----------------|-----------------|-----------------|
|  | 1 <sup>st</sup>          | 2 <sup>nd</sup> | 3 <sup>rd</sup> | 4 <sup>th</sup> | 5 <sup>th</sup> |
| <i>Polio (OPV)</i>                             |                          |                 |                 |                 |                 |
| <b>DTP and/or DT/TD</b>                        |                          |                 |                 |                 |                 |
| <b>Measles (Rubella — 10 day, red measles)</b> |                          |                 |                 |                 |                 |
| <b>Rubella (German measles -3-day measles)</b> |                          |                 |                 |                 |                 |
| <b>Mumps</b>                                   |                          |                 |                 |                 |                 |

**Health examiners stamp/signature:** \_\_\_\_\_

**Immunization Requirements:**

1. DTP: 4 doses with the last dose to be administered after 2 yrs. old, or a 5<sup>th</sup> is required.
2. Polio: 3 doses with the last dose to be given after 2 yrs. old, or a 4<sup>th</sup> is required.
3. MMR: 1 dose to be given after 12 months of age.
4. TB Test: Required before entering school for the first time.

**Part III — Physician Completes:**

Required for all new students, as well as any returning students who have had a change in childhood disease status.

**Childhood Diseases:** Please insert date treated.

Chicken Pox \_\_\_\_\_ Mumps \_\_\_\_\_  
Rheumatic Fever \_\_\_\_\_ Whooping Cough \_\_\_\_\_  
Measles \_\_\_\_\_ German measles \_\_\_\_\_  
Pneumonia \_\_\_\_\_ Other \_\_\_\_\_

**Part IV — Physician Completes:**

Required for all new students as well as returning students who have had a change in health status in the last 12 months.

Certification of examination: Please initial any tests or evaluations you performed. Indicate any pertinent results.

| Tests and Evaluations  | Initials | Date Completed | Results |
|------------------------|----------|----------------|---------|
| Health and development |          |                |         |
| Vision screening       |          |                |         |
| Audiometric screening  |          |                |         |
| TB Tests               |          |                |         |
| Appropriate lab tests  |          |                |         |

This is to certify that \_\_\_\_\_ has received the health screening and evaluation required by state law.

**Signature of Doctor/Health Examiner** \_\_\_\_\_ **Date** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**License #** \_\_\_\_\_