THE SEVEN HILLS SCHOOL
2024-2025 MEDICAL RECORD

Name (Last, First)	Date of Birth	Gender	Grade	Division

Parent/Guardian 1 Name	Home Address	Phone Number

Parent/Guardian 2 Name	Home Address	Phone Number

Past Illnesses, injuries, surgery, scars or hospitalization:

Special Needs and Conditions:

Allergies:

Medications:

DTaP						
Polio						
HiB						
Hep B				**Hep A**		
MMR				**DT**		
Varicella				**COVID # 1**		
Tdap				**COVID # 2**		
Meningococcal				**COVID Booster**		

TB Date _____ TB Type_____ TB Result _____

*TB Test is requirement for those students at high risk.

_____was examined by me and is free from communicable disease. This student is able to participate in all activities including classroom/academic activities and physical education classes.

Signature of Provider **Date of Exam**

Provider's Name and Address **Phone**