Instilling Goodness Developing Virtue School
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Boys Division (707) 468-1138 dvbs@drba.org
Girls Division (707) 468-3847 dvgs@drba.org

STUDENT MEDICAL FORM

First Name: ____________________ Last Name: ____________________ Date of Birth: ____ / ____ /_____

This form must be completed and signed by your healthcare provider. Please answer all questions accurately, provide details where applicable, and attach any supporting documents.

Questions	Yes / No	If yes, please describe below.
Chronic Medical Conditions	☐ Yes ☐ No	
Behavioral/Mental Health History	☐ Yes ☐ No	
Surgical History / Hospitalizations	☐ Yes ☐ No	
Current Medications	☐ Yes ☐ No	
Allergies	☐ Yes ☐ No	Food:
		Insect:
		Environmental:
		Medication:
Social History / Habits (tobacco, alcohol, substance use, sleep, eating, etc.)	☐ Yes ☐ No	
Other Health Problems	☐ Yes ☐ No	
Family Medical History	☐ Yes ☐ No	
Immunizations	Please attach a copy of immunization records.	
Vision	Results:	☐ Glasses ☐ Contact Lenses
Hearing	Results:	
Tuberculin (TB) Test*	Results: ☐ Positive ☐ Negative	Date of Test:

**A positive TB test requires a chest x-ray. The test must be within the past 12 months.*

Applicable to female students that have begun menstruation.	
Menstrual History	Cramps/Other Pain: ☐ Yes ☐ No / Heavy Bleeding: ☐ Yes ☐ No / Irregularities: ☐ Yes ☐ No

Name of Physician: ______________________________ Phone : ________________________

Signature of Physician: ____________________________ Date of Examination: _______________