Administrative Office
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Student Health Examination School Year 2011-2012

STUDENT INFORMATION: TO BE COMPLETED BY PARENT OR GUARDIAN.

Student Name (Last, First, Middle)		Age	Date of Birth
Home School District	Grade	Sex Male ☐ Female ☐	
Home Address (Street, City, State, Zip)			Home Phone (Including Area Code)
☐ Parent Name (Last, First, Middle) ☐ Guardian			Work Phone (Including Area Code)

Has the Student had, or now have, any of the following? Reason Date Place

☐ Asthma ☐ Cancer ☐ Hospitlization ______
☐ Allergies ☐ Tuberculosis ☐ Surgery: What kind? ______
______ ☐ Orthopedic Problems
☐ Congenital Heart Disease ☐ Vision Problems ☐ Serious Illness ______
☐ Convulsions ☐ Hearing Problems ☐ Serious Accidents ______
☐ Diabetes ☐ Speech Problems ☐ Other Problems / Limitations ______

TO BE COMPLETED BY THE HEALTH CARE PROVIDER.

Child's History:

Family History:

PHYSICAL EXAMINATION: Height ______(%) Weight ______(%) Blood Pressure: ______ Pulse: ______

General Appearance (Nutritional Status): ______

NL	AB		NL	AB		NL	AB		NL	AB		NL	AB	
☐	☐	Heent	☐	☐	Lungs	☐	☐	Extremeties	☐	☐	Psycho / Social Development			
☐	☐	Dental Status	☐	☐	Cardiovascular	☐	☐	Back	☐	☐	Languauge			
☐	☐	Neck	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Behavorial			
☐	☐	Lymph	☐	☐	Genito Urinary	☐	☐	Neuro	☐	☐	Gross Motor	☐	☐	Fine Motor

Describe Abnormalities:

SCREENING TESTS:	Date	Results		Date	Results	Vision	Date	Results
Hematocrit / Hemoglobin	______	______	Urinalysis	______	______	Far	______	______
HOB Electrophoresis	______	______	Audio / Sweep	______	______	Near	______	______
Other ______	______	______	Threshold	______	______	Fusion	______	______
						Color	______	______

LEAD	Date	Results	TB: Mamtoux	Date	Results		Date	Results
Venous Lead	______	______	PPD Imflanted Read	______ ______	☐ Negative ______MM ☐ Positive ______MM	Chest X-Ray	______	______

IMMUNIZATION—DATES

DPT or Dt or Td	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Measles	__/__/__	__/__/__
POLIO: TOPV (Sabin)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Mumps	__/__/__	__/__/__
IPV (Salk)	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	Rubella	__/__/__	__/__/__
HIB	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	__/__/__	MR	__/__/__	__/__/__
Varicella / Chicken Pox	__/__/__	__/__/__	Hepatitis B	1. __/__/__	2.__/__/__	3.__/__/__	MMR	__/__/__	__/__/__

RECOMMENDATIONS: PLEASE SPECIFY LIMITATIONS and/or SPECIAL ALERTS (i.e. allergies, medications, precautions)

☐ Full Physical Activity ☐ Restrictions (Please Specify) ______

Physician Name(Print): ______ Date: ______

Physician Signature: ______ Address: ______