Health Examination Form
Health History Form

Student Name: ______________________________ **Date of Birth:** ___________
Address: ______________________________ **Phone #:** ______________
Gender: ____________ **Current Grade:** ______________
Name of Parent(s)/Guardian(s): ______________________________
Name of School Attending: ______________________________

Immunization Information (List Month/Day/Year)

DTaP, DTP, DT, DTAP, TDAP 1______ 2______ 3______ 4______ 5______ 6______

Polio 1______ 2______ 3______ 4______

MMR 1______ 2______

HIB 1______ 2______ 3______ 4______

Hepatitis B 1______ 2______ 3______ 4______

Varicella 1______ 2______ and/or date of Chicken Pox Disease ________

Pneumococcal 1______ 2______ 3______ 4______ 5______

Immunizations given today: ______________________________

Physical Exam

Height ______ **Weight** ______ **Blood Pressure** ______/______ **Pulse** ______

Vision Screening: Correction Y N
Near Vision
Right Eye 20/____
Left Eye 20/____

Far Vision
Right Eye 20/____
Left Eye 20/____

Hearing Screening:
Audio Test 500 1000 2000 4000 Pass/Fail
Right Ear ______________________________
Left Ear ______________________________

	Normal	**Abnormal**	**Comments**
Nutritional Issues	______	________	______________________________
Scalp/Skin	______	________	______________________________
Head/Neck	______	________	______________________________
Mouth/Teeth/Gums	______	________	______________________________
ENT	______	________	______________________________
Heart	______	________	______________________________
Lungs	______	________	______________________________
Abdomen	______	________	______________________________
Musculo-Skeletal	______	________	______________________________
Posture/Scoliosis	______	________	______________________________
Neurological	______	________	______________________________
Additional Comments	______	________	______________________________

(over)

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List Allergies to:

Medications: _______________________________ Environmental: _______________________

Food: _____________________________________Insects: _____________________________

Other: ____

Medications this student is taking (including dose and frequency): ___________________

____

____

Health Conditions/Programs and Comment:

____ Headaches ____

____ Seizure Disorder ____

____ Eye/Vision Problems ____

____ Ear/Hearing Problems ____

____ Speech Problems ____

____ Heart ____

____ Asthma/Other Lung Problems ____

____ Diabetes ____

____ Stomach Problems ____

____ Bowel/Bladder/Kidney Problems ____

____ Skin Problems ____

____ Physical Handicap ____

____ Behavior Problems ____

____ Learning Problems ____

____ Surgical Procedures ____

List any other illnesses/injury or health information: _________________________________

____

____

Do any of the above conditions limit:	Classroom Activities?	Yes _____ No _____
	Physical Education?	Yes _____ No _____
	Competitive Sports?	Yes _____ No _____

If yes, please describe: ____

____

On the basis of this exam, does this student need further referral or evaluation? _______

____

____ ________________

Signature of Licensed Physician, Physician's Asst., Nurse Practitioner **Date of Exam**