

Health History

Student's Name: _____ Date of Birth: _____ Sex: Male () Female ()

Your accurate and thorough answers help us to better serve your child.

To the best of your knowledge, has your child had any problems with following? Please check yes or no.

Medical Condition	Yes	No	Comments if "Yes"	Medical problem	Yes	No	Comments if "Yes"
ADD or ADHD				Hearing Loss			
Anemia				Heart disease			
Anxiety/Panic Attacks				Hepatitis			
Asthma				Pneumonia			
Behavioral problems				Rheumatic Fever			
Bleeding Disorder				Scoliosis			
Chronic ear infection				Seizures			
Developmental problems				Substance Abuse			
Depression				Tuberculosis			
Diabetes				Vision Problems			
Excessive Fatigue				Other			

* Describe any serious illness, surgery, injuries, or hospitalizations: _____

* Describe any other important health-related information about your child (i.e., feeding tube, hearing aid, Insulin device, etc.): _____

* Has your child had any psychological testing & evaluation, or therapy? No () Yes ()

If yes, please explain and attach the copy of the most current evaluation _____

Immunization History

Student's Name: _____ Date of Birth: _____ Sex: Male () Female ()

Immunization	Record complete dates (yyyy/mm/dd) of vaccine dose given				
DPT	①	②	③	④	⑤
Td Booster	①				
Poliovirus	①	②	③	④	
MMR	①	②			
Hepatitis B	①	②	③		
Varicella	①	Date of Varicella Disease:			
Other					
TB Screening (to be completed by a school nurse)					

List all prescription and over-the-counter medications your child takes regularly:

Name of medication	Reason	Dose/How often

Does your child have any allergies? None ___ Yes ___ (If yes please describe)

Specify Allergies (Medication, food, environment, or other)	Describe Reaction	Treatment



Physical Examination

Student's Name (last, first): _____ Date of Birth(yyyy/mm/dd): _____ Sex (Male/Female)
 Height: _____ cm Weight: _____ lbs/kg Blood Pressure: _____ mmHg
 Hemoglobin: _____ Urinalysis: _____
 Tuberculin screening: skin test () or chest x-ray (): Date _____ Result: _____

System Examination	Normal	Abnormal	Comments about Findings	System Examination	Normal	Abnormal	Comments about Findings
General Appearance				Mouth/Teeth			
Skin				Neck			
Head				Chest			
Eyes	External			Heart			
	Fundi			Lungs			
Ears	Canals			Abdomen			
	Tympanic Membrane			Bones, Joints, Muscles			
Nose				Posture/Range of Motion			
Throat				Neurological			
Estimated Developmental Level	Cognitive Development						
	Speech/Language Development						
	Social/Emotional Development						

Recommendations: _____

Physician's/Nurse practitioner's Name (print): _____ Signature: _____ Date: _____