Student Health Examination

Date: ________________

Student's Full Name: ____

Birthdate: __________________ Age: __________ Race: ___________ Sex: _________________

Address: ____

Parent/Guardian: ____ Phone: _______________

A. HEALTH EXAM

Height _______ Weight _______ Blood Pressure _______ Pulse _______

(x) Normal = N; Abnormal = A	N	A	Comment: Abnormal Findings
1. Appearance			
2. Skin/Nose			
3. Head/Scalp			
4. Eyes			
5. Visual Acuity (R & L)			
6. Ears			
7. Auditory Acuity (R & L)			
8. Nose/Throat			
9. Mouth, Teeth, Gums			
10. Chest/Lungs			
11. Heart			
12. Abdomen			
13. Genitals & Anus			
14. Musculo-Skeletal			
15. Neurological			
16. Alertness			
17. Emotional/Mental/Behavior			
18. Handicap, physical/other (specify)			
19. Activity Restrictions (specify)			
20. Abuse, substance/physical/emotional			
21. Other			

(Over)

B. HEALTH HISTORY (Serious illness or injuries: explain)

____

____

____

(attach narrative if additional space is needed)

C. LABORATORY (as indicated)

Hemoglobin/Hematocrit ___________ Stool (O&P) ___________ Lead ___________ Urinalysis ___________

Tuberculin Test: Type ________________ Date ________________ Results _____________

Are medications at school necessary?	Yes _____	No _____
Are special medical treatments necessary at school?	Yes _____	No _____
Are there any modifications necessary?	Yes _____	No _____
Is special seating required?	Yes _____	No _____

Comment on any of the above statements:____

____

____

Classifications for physical education activity:

A. _____Unrestricted activity
B. _____Slightly modified activity - under observation
C. _____Restricted

Please define any restrictions or modifications: ____

____

____

Any additional remarks, recommendations, or orders for school: ___________________________________

____

____

Signature of examining physician: ______________________________________ **Date:** ________

Clinic:____

Address: ____**Phone:** ____________________