STUDENT HEALTH EXAMINATION CARD **School:**_____ **Grade:**_____

Name (Last, First, MI) :_____ **Birthdate:**___/___/___ **Male** **Female**

Parent / Guardian's Name :_____ **Phone Number (H):**_____ **(W):**_____

Address :_____ **Physician:**_____

DtaP/Td	Tdap	Polio		MMR	
Date		Date	/ /	Date	/ /
Date		Date	/ /	Date	/ /
Date		Date	/ /	MMR-V	
Date		Date	/ /	Date	/ /
Date		Date	/ /	Date	/ /
Hepatitis A		**Meningococcal**		**Varicella (Chicken Pox)**	
Date	/ /	Date	/ /	Date	/ /
Date	/ /	Date	/ /	Date	/ /
HPV		**Hepatitis B**		OR Date of Chicken pox disease: /	
Date	/ /	Date	/ /		
Date	/ /	Date	/ /		
Date	/ /	Date	/ /		
		Date	/ /		

Ht: ____ **Wt:** ____

BMI % ____

B/P: ____

Pulse: ____ **Respirations:** ____

Hct: ____ **Lead Test:** ____

PHYSICAL EXAMINATION: **General Appearance:**_____

Nutritional Status:_____ **Hematocrit or Hgb:**_____ **Urinalysis:**_____

Skeleton Development:_____ **Posture:**_____ **Scoliosis:**_____

Scalp & Skin:_____ **Lymph Nodes:**_____ **Neck:**_____

Ears:_____ **Nose:**_____ **Throat:**_____ **Mouth:**----------

_____ **Teeth & Gums:**_____ **Speech:**_____

Heart:_____ **Lungs:**_____

Abdominal Exam:_____ **Hernia:**_____

Upper Extremities:_____ **Lower Extremities:**_____

Neurological Exam:_____ **Mental Development:**_____

Health History: check any past or present illness of this child the school should be made aware of, such as:

☐ **Anaphylaxis:**_____ ☐ **Asthma**

☐ **Diabetes:**_____ ☐ **Heart Disease:**_____

☐ **Physical Handicaps:**_____

☐ **Serious Injuries:**_____

☐ **Seizures:**_____

☐ **Other:**_____

Hearing Screen: **Pass** **Fail**

Audio	**500**	**1000**	**2000**	**4000**	**6000**
R Ear					
L Ear					

KINDERGARTEN/OUT OF STATE TRANSFER VISION EXAM:

With Correction	W/O Correction 16 in	With Correction 20 ft	With Correction 16 in
R Eye 20 / ____	R Eye 20 / ____	R Eye 20 / ____	R Eye 20 / ____
L Eye 20 / ____	L Eye 20 / ____	L Eye 20 / ____	L Eye 20 / ____

	Pass	Fail
Amblyopia	____	____
Strabismus	____	____
Internal Eye Health	____	____
External Eye Health	____	____

1. **Is this child subject to any illness which may result in a classroom emergency?** ☐ **Yes** ☐ **No**
   If yes, please describe:_____

Is this child subject to any condition which limits: Classroom Activities? ☐ **Yes** ☐ **No** **Physical Education/Competitive Sports?** ☐ **Yes** ☐ **No**
If yes, please describe:_____

3. **Is this child taking any medications?** ☐ **Yes** ☐ **No** **If yes, please describe:** _____

Any other remarks or suggestions: _____ ***Referrals to : (ENT, Ortho, etc…)***_____

Date of Exam:___/___/___ **Office Phone #:**_____ **MD/PA/NP Signature:**_____