



School Health Examination

Return form to your child's school prior to the first day of entrance

Parent/Guardian Complete this top portion:

School Name _____

Name _____ (Last) _____ (First) _____ (Middle) M F Birth Date _____

Parent/Guardian Name(s) _____ Home Phone _____

Significant Past Health History or present illness: _____

Health History

	Yes	No	Remarks
Chronic Recurrent Illness			
Serious Injury (bone, joint, head)			
Hospitalizations/ ER visits			
Asmtha			
Diabetes			
Seizures			

	Yes	No	Remarks
Headaches			
Vision Impairment			
Hearing Impairment			
Kidneys			
Fainting			
Recurrent Skin Problem			
Other			

Physical Health Examination (examining practitioner to complete this section):

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No Hearing by 20db audiometry: R _____ L _____

Hearing Subjective questions (for 7th grade) Pass _____ Fail _____ If Fail: Audiometry R _____ L _____

Height _____ in. Weight _____ lbs. BMI _____ % BMI _____ Blood Pressure _____ / _____

Allergies _____ Current medications _____

	Normal	Abnormal	Remarks
Eye			
cover test			
corneal reflection			
ENT			
Dental			
Heart			
Lungs			
Abdomen			

	Normal	Abnormal	Remarks
Genitourinary			
Skin			
Extremities			
Musculoskeletal			
Spine/scoliosis			
Nutritional status			
Emotional status			

Sports/Physical Education approved? Yes No Limitations: _____

For 7th Grade: Competitive inter school sports approved? Yes No Limitations: _____

Health Care Provider Signature _____ Print Name _____ Exam Date _____

Clinic Name _____ Phone _____ Fax # _____