

PHYSICIAN TO COMPLETE THIS FORM

2022-2023

The Shlenker School
Fax: 713-270-6114

NAME of Student: _____

Weight: _____ lbs. Height: _____ in. B/P: _____

TB Risk Assessment: No Risk Positive, referral

Activity Restrictions: None Yes (specify):

*** Date of Last Physical:** ____/____/____

Medication: Child takes medicine for specific health condition(s):
Please note; If to be administered at school, write Rx here or attach! Be specific.

Special Diet: * None Specify: _____

Behavioral Issues/Mental Health Concerns:*

Special Needs, Modifications, Special Equipment* (Specify):

VACCINE	DATE	DATE	DATE	DATE	DATE
DTaP, DPT, DT, Td, Tdap					
Polio					
Measles, Mumps, Rubella (MMR)					
Haemophilus Influenza B (HIB)					
Hepatitis B					
Varicella (Chicken pox)					
Hepatitis A					
Pneumococcal Conjugate					
Influenza, (list type if known)					
RotoVirus (circle or Designate): Rotorix, RotoTec					
Other (Meningococcal, TB, HPV, etc.)					
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Individualized Healthcare plan (IHP) needed

(e.g. Emergency management of: severe allergy, asthma, diabetes, seizure disorder etc.)

Summary of findings:

- Well child; no conditions identified of concern to school program or activities.
- Conditions identified that are important to schooling or physical activity (explain here):

*** Required**

Health Care Professional's Certification: I certify that on this date I have examined the above student and noted any limitations in participation, their current medical status, special needs, and immunizations of record.

Physician's Name: _____

Physician's Signature: _____ **Date:** _____

