PHYSICIAN TO COMPLETE THIS FORM **2024-2025**

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: _____ **Date:**_____

Physician's Signature: _____

THE SHLENKER SCHOOL