

# STANDARD HEALTH EXAMINATION RECORD

ORGANIZATION OR SCHOOL \_\_\_\_\_

NAME \_\_\_\_\_ PARENT OR GUARDIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
LAST FIRST INITIAL

ADDRESS \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

IN EMERGENCY NOTIFY \_\_\_\_\_ ADDRESS \_\_\_\_\_ Phone \_\_\_\_\_

HEALTH HISTORY (CHECK DISEASES)	ALLERGIES	CHRONIC OR RECURRING ILLNESS	SUGGESTIONS FROM PARENTS
CHICKENPOX ---	HAYFEVER ---	EAR INFECTIONS _	
MEASLES ---	ASTHMA ---	HEART DISEASE ---	
GERMAN MEASLES ---	DRUGS ---	CONVULSIONS _____	
MUMPS ---	INSECT STINGS ---	DIABETES _____	
	IVY, OAK, ETC. ---	BEHAVIOR _____	
	FOOD ---	OTHER _____	
OPERATIONS OR SERIOUS INJURIES (DATES) _____			
HOSPITALIZATIONS _____			
OTHER DISEASES OR DETAILS OF ABOVE _____			
COMMENTS WHERE APPLICABLE (CAMPS OR BOARDING SCHOOL) _____			

FADING \_\_\_\_\_ SLEEP DISTURBANCES \_\_\_\_\_ BED WETTING \_\_\_\_\_  
 CONSTIPATION \_\_\_\_\_ OTHER \_\_\_\_\_

SPECIFIC ACTIVITIES TO BE ENCOURAGED \_\_\_\_\_  
 RESTRICTED \_\_\_\_\_

SPECIAL MEDICAL OR DIETARY REGIMEN TO BE CONTINUED (SPECIFY) \_\_\_\_\_

### IMMUNIZATIONS

IMMUNIZATIONS	YEAR PRIMARY SERIES COMPLETED	YEAR OF LAST BOOSTER
DIP.	_____	_____
DIPHTHERIA	_____	_____
TETANUS	_____	_____
WHOOPING COUGH	_____	_____
O.A.I. POLIO	_____	_____
MEASLES	_____	_____
SMALL POX	_____	_____
MUMPS	_____	_____
OTHER	_____	_____
TUBERCULIN TEST	TYPE _____ YEAR LAST GIVEN _____	RESULT _____

### PHYSICAL EXAMINATION

AN EXAMINATION FOR SOME OTHER PURPOSE WITHIN THE PAST SIX MONTHS IS ACCEPTABLE.

DATE OF EXAMINATION \_\_\_\_\_

CODE: SATISFACTORY   
 NOT SATISFACTORY   
 NOT EXAMINED

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ B.P. \_\_\_\_\_

APPEARANCE NUTRITION \_\_\_\_\_

WITHOUT GLASSES      WITH GLASSES  
R20/ L20                  R20/ L20/

EYES \_\_\_\_\_

EARS \_\_\_\_\_ HEARING R \_\_\_\_\_  
 L \_\_\_\_\_

NOSE \_\_\_\_\_

THROAT \_\_\_\_\_

TEETH \_\_\_\_\_

HEART \_\_\_\_\_

LUNGS \_\_\_\_\_

ABDOMEN \_\_\_\_\_

GENITALIA \_\_\_\_\_

HERNIA \_\_\_\_\_

SKIN \_\_\_\_\_

MUSCULOSKELETAL \_\_\_\_\_

URINALYSIS \_\_\_\_\_ HGB \_\_\_\_\_

OTHER NOTES \_\_\_\_\_

PHYSICIAN'S COMMENTS AND RECOMMENDATIONS  
 GIVE DETAILS OF MANAGEMENT OF SIGNIFICANT ILLNESSES

THIS PERSON IS IN SATISFACTORY CONDITION AND MAY ENGAGE IN ALL USUAL ACTIVITIES EXCEPT AS NOTED.

\_\_\_\_\_, M.D.  
 STREET \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_